HEALTH CARE FINANCING ADMINISTRATION LONG TERM CARE RESIDENT ASSESSMENT INSTRUMENT VERSION 2.0 QUESTIONS AND ANSWERS AUGUST 1996

Preface

August 29, 1996

This Q & A Document contains 249 question/response sets, based on questions directed to HCFA Central office concerning RAI Version 2.0, since our January 1996 implementation. The number of questions we received indicates the industry's interest and commitment to accurately using the MDS 2.0.

The document is formatted in a way that will hopefully allow easy use as a reference to answer MDS 2.0 questions, and as a complement to the MDS Version 2.0 User's Manual. Refer to the Table of Contents for the sequencing and arrangement of questions/responses.

The Q & A document for Version 2.0 is published by the Health Care Financing Administration (HCFA) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities.

The Q & A document was compiled by HCFA Central Office staff: Sue Nonemaker, Cindy Hake, Susan Joslin and Mary Weakland. We would like to acknowledge Dr. John Morris, Kathy Murphy, Betty Cornelius and Bob Godbout for input on these materials and for their continued collaboration in refining the RAI, and enhancing its efficacy. We would also like to thank Yvonne Anderson for preparing this document for publication. We hope you will find the document as useful as we found it worth the development effort.

Please refer any additional RAI questions to the State RAI Coordinator identified in Appendix A of the RAI Version 2.0 User's Manual. Questions that cannot be resolved at the State level should be referred to the HCFA Regional office RAI Coordinator. Questions that cannot be resolved at the Regional level should be referred to the HCFA Central Office:

MDS Coordinator
Health Care Financing Administration
7500 Security Boulevard
Mail Stop: S2-11-07
Baltimore, MD 21244

Finally, we thank you for your continued enthusiasm in implementing Version 2.0.

TABLE OF CONTENTS

Note: In some instances, questions seemed suited to more than one section of this document. Where this overlap existed, the question was placed under the Section heading to which it was best suited.

(Also, please note that on 2/19/97, three minor changes were made to the Q & A document. The changes made were: Question #41 The original question beginning "How should items G1c and d," now correctly reads "How should items G1e and f," Question #43 The original question beginning "Is standing balance (MDS item G3b)" now correctly reads "Is standing balance (MDS item G3a)". Question #186 In the second sentence of the response, the original phrase beginning "but in no case less than 14 days" now correctly reads "but in no case later than 14 days". Also, the Answer to Question #82 originally said to code a healing stage 3 Pressure Ulcer as “3”. This was a typo. It should be coded as a “2”. Pressure Ulcers are coded on the MDS as they are currently seen, as per the instructions in the Long Term Care RAI User’s Manual version 2.0, October 1995.)

MDS Items AA-AD, Questions on the Basic Assessment Tracking Form and Face Sheet

1: Are facilities required to complete the Basic Assessment Tracking Form (Section AA) at the current time or only after HCFA's MDS automation requirements are effective?

A: A paper or hard copy of the Basic Assessment Form must accompany each Full, Quarterly, or State required assessment, effective as of the date of MDS 2.0 implementation. The User's Manual reference for this question is on page 3-1. The reference on page 2-13 of the User's Manual is incorrect.

2: In Section AA #7, is the Medicaid Number intended to capture the case number or the recipient number?

A: The number in Section AA #7 is the Medicaid Recipient Number. This is a 14 digit code that tracks the person across all provider types. The Recipient Number is a unique identifier number assigned by the State Medicaid office. Questions regarding the Medicaid number can be referred to the State Medicaid office or the State RAI Coordinator.

3: Is a reentry form required when a resident returns from a hospital if they were not discharged from the nursing facility?

A: Yes, a Discharge Tracking form should have been completed when the resident was transferred to the hospital. Upon return, complete the Reentry form. See the User's Manual reference on page 3-12.

4: When must the Face Sheet be submitted? Does the Face Sheet need to be updated to Version 2.0 or will the old one suffice?

A: When HCFA's MDS automation requirements are effective, Face Sheet information on Version 2.0 must be submitted with the first assessment record that is submitted. For residents admitted prior to implementation of Version 2.0 of the MDS, use information on the original Face Sheet to complete the Version 2.0 Face Sheet (i.e., crosswalk data from original Face Sheet items measuring the same thing on Version 2.0). Three new items appear on the Version 2.0 Face Sheet (i.e., AB4-Zip Code; AB7-Education, and AB11-Date Background Information completed). These should be completed prior to submission. For residents admitted after implementation of Version 2.0, the Face Sheet information should be submitted with the first assessment record that is required after HCFA's MDS automation requirements are effective.

5: The Briggs forms have a Face Sheet attached to every MDS. Is a Face Sheet required on every MDS?

A: No. The Face Sheet is completed once, when the resident first enters the facility. The Face Sheet is also required if the person re-enters the facility after a discharge where return had not been previously expected. If MDS forms are purchased in a "set", discard the Face Sheet page or draw a line through it when it does not apply to the current assessment.

6: What are the time frames for completion of the Basic Assessment Tracking form?

A: It must be completed within the same time frame as the required assessment (e.g., within 14 days after admission).

7: How long is the Face Sheet (Section AB, AC, and AD) to be kept in the active record?

A: The Face Sheet is completed once and is to remain a permanent part of the resident's record. While part of HCFA's original RAI Training Manual, this statement was inadvertently omitted in the User's Manual for Version 2.0. If the resident is permanently discharged, (without expectation of return), and then comes back to the facility, a new Face Sheet must be completed. The User's Manual reference for this question is on page 3-14.

8: What is the reason for requiring a signature at Section AD?

A: The signature at AD covers Sections AB and AC, which is maintained in the active record throughout the resident's stay. The signature at R2 applies to information entered in Sections A through R. Sections A through R can be thinned after 15 months, thereby separating the R2 signature from Sections AB and AC. Sections AB and AC remain in the chart.

9: Regarding MDS item AB2, "Admitted From (at Entry)", which code is most appropriately used for a licensed residential facility?

A: Use code 3, "Board and care/assisted living/group home".

10: Regarding item AB8a, "Primary Language", if a resident spoke English as a second language, but reverted to the original language due to their present condition (cognitive deficit, CVA, etc.…), do you code the language the resident is currently speaking, or the language they used to speak, prior to the onset of their current condition?

A: Code as primary the language the resident currently speaks or understands.

11: On page 3-21 of the User's Manual which refers to item AB9, what is meant by "major life activities"?

A: The language used is adapted from PASARR. Refer to 42 CFR Subpart C 483.102 b (ii), for a definition of "level of impairment", which discusses functional limitations in "major life activities" according to (A) Interpersonal function, (B) Concentration, persistence and pace and (C) Adaptation to change.

12: What is the purpose of the Basic Assessment Tracking forms?

A: The Basic Assessment Tracking form identifies the resident in a computerized environment. The Discharge and Reentry Tracking forms provide key information to identify and track the movement of residents in and out of the facility.

13: Is the Reentry Tracking Form kept with the MDS or computer information only?

A: Keep the Discharge and Reentry Tracking forms along with all RAI information (MDS, Quarterly reviews, RAP Summary forms) for a 15-month period. It is not necessary to maintain a hard copy in facilities where the entire clinical record is stored electronically, (see manual, page 2-19 for related criteria). The User's Manual reference for this response is on page 2-18.

14: How soon must the Discharge Tracking form be completed, and where is it kept?

A: The User's Manual reference for this response is on page 3-2. The Discharge Tracking form is completed when the resident is discharged from the facility (i.e., stays overnight or is admitted to another health care facility). It is not completed for therapeutic or social leave. The Discharge Tracking form must always be completed at the time of any discharge from the nursing home and must be maintained in the active clinical record along with the required 15 months of RAI information. Once HCFA's MDS automation requirements are effective, it is anticipated the facilities will have to encode this information within 7 days after the resident's discharge from the facility. The 7-day time frame will also apply to encoding of the Reentry Tracking information for residents who return to the facility.

15: Does the Discharge Tracking form apply to outpatient or 23 hour observation stays when the resident is not actually discharged from the facility?

A: No. The Discharge Tracking form is completed only when the resident is out of the facility for an overnight stay, except for a temporary visit home. This applies regardless of the facility's policy and procedure for discharge or opening and closing records.

16: In reference to #8 on the MDS, Reason for Assessment, please explain "discharged-- return not anticipated."

A: The User's Manual reference for this response is on page 3-11, #6 (see form on page B-16, Section AA., #8, a6). This code is used on the Discharge Tracking Form only and applies when a resident is permanently discharged from a nursing home (as opposed to situations in which the record is closed, temporarily discharging the resident from the facility, during a brief absence such as a hospitalization). This provides a means of "closing" the record of any resident at the point of discharge from the facility (when return is not anticipated).

17: What is the intent of the statement "skip if not discharged" on the Discharge Tracking form, Section R?

A: Please disregard this statement, which was inadvertently left on the final version of the form. This line may be deleted by forms manufacturers and software vendors.

18: Is it necessary to keep blank Discharge and Reentry forms in the resident's clinical record until they are needed?

A: No. Include in the active record once completed.

19: If Reentry forms are not required until HCFA's computerization requirements are effective, what forms are required to indicate return to the facility after a hospital stay?

A: The MDS Version 2.0 Discharge and Reentry Tracking forms are only required in States that require submission of MDS data. Otherwise, facilities are not required to complete any Assessment form when a resident returns from a hospital stay, unless the resident has experienced a significant change in status. Upon return, the resident's status should be evaluated for possible Significant Change.

20: How soon after discharge or reentry must the Discharge or Reentry Form be completed?

A: Complete these forms no later than 7 days after the event.

21: How is Section AB dated when additional information in AB and AC is received late?

A: As the "Background Information" items are not repeated in subsequent assessments, this is the only place where additional information can be added or changed after the original assessment completion date.

In a paper system, fill out a new form with the new information and date of the assessment in AB11. Facilities may also fill in the missing information on the previously completed form, with the entries identified with the new date and signature of the assessor. In a computer system, the new information should be entered and a new print-out generated. Item AB11 is used to indicate when this information is entered. The User's Manual reference for this question is on page 3-22 and 3-23.

Questions on Items in MDS Sections A Through G

22: On the Quarterly and Annual Assessments, what is the information on Item A3a used for?

A: Item A3a is a critical concept. All Assessments must have an Assessment Reference Date that indicates the period of common observation for all assessment items. This Assessment Reference Date is the designated endpoint of the observation period for that particular Quarterly or Full assessment. All MDS items are coded by observing the resident's status or performance back in time from this point. For example, if the Assessment Reference Date for an Annual assessment is May 27, the period of common observation for 7-day items is May 21-27. For 14-day items, the common observation period is May 14-27, and so on. The User's Manual reference for this question is on page 3-30.

23: The top of each page of the MDS form contains the wording "Numeric Identifier", followed by a blank line. What is this used for?

A: This is an optional item that the facility may use to identify a resident as they gather information on the MDS. In a paper environment where pages may be separated, this item could aid the facility in gathering the form together. See the example shown on pages 4-24 through 4-30 in the User's Manual. This is not a HCFA requirement.

24: Should documents supporting advance directives be maintained in the resident's active clinical record for surveyor review?

A: 42 CFR 483.10 requires facilities to protect and promote the rights of each resident, including the right to "formulate an advanced directive". There is no regulatory text specifying a location for advanced directive information. Unless there are State codes or regulations regarding this matter, the method of communicating the information is up to the facility. If documentation is not available in the resident's clinical record, facility staff should be the source of this information, and surveyors will assess whether the staff knowledge and actions are in agreement with resident/family wishes. Some facilities elect to maintain the information in the resident's clinical record. For advanced directives to be included in item A10, the User's Manual (page 3-39) indicates that documentation must be available in the record.

25: Where would evidence of task segmentation, (item G7) be found? If scored "yes", is further evaluation required?

A: This information may be documented anywhere in the clinical record (e.g., nurse's notes or therapy notes), or it may not be documented at all, as the MDS is considered a primary source document. Since item G7 is not part of the RAP trigger, assessment is not necessarily required. It makes sense however, that staff should be knowledgeable about how to break down task(s) for individual residents (i.e., based upon that individual's needs) so that they may integrate task segmentation into the resident's care.

26: I have advised facilities that the reliability of entering the data in the ADL section is considerably improved by completing the Self Performance column first for all items and then returning to the top and completing the Support column because of the differences in the scales to score these two columns. Facility staff say that computer programs will not let them complete the form in the manner I've suggested. Is that a problem?

A: Your suggestion may be of value to staff who are new to the process and who are completing a paper form of the MDS 2.0. Studies have shown that reliability is indeed improved by using this method. However, HCFA cannot direct software vendors to make this change. If desired, facilities should contact their software support representative who may alter your system to meet the facility's needs.

27: If a resident demonstrates a behavior after the assessment observation period is ended, we document this in the clinical record and address the behavior on the care plan. How is this behavior reflected in the RAI assessment?

A: The facility maintains a responsibility to address issues and behaviors relevant to a resident whether or not they occur during the MDS observation period. Such information should be documented in the clinical record and referenced as necessary to support decisions of whether and how to care plan. Although an event may not occur during the MDS observation period (and therefore will not be coded on the MDS), the assessor has the professional responsibility to make a decision regarding the review of RAPs that did not trigger. Ongoing assessment, planning and evaluation are basic components of clinical practice. Refer to the problem identification model addressed in chapter 1 of the RAI User's Manual.

28: During the MDS assessment observation period, a resident is assessed as needing medical evaluation and treatment for depression, and the facility alerts the physician about this need. The evaluation is completed and treatment is begun after the MDS observation period is over. How is this reflected in our assessment and care planning?

A: The assessment process in ongoing. Changes in the resident's status and plan of care (i.e. physician's orders, delivery of care and services, the resident's response to care and treatment provided, etc.) should be documented clearly in the clinical record after the RAI is completed. Revisions should be made to the care plan as a result of an ongoing assessment and evaluation process and as appropriate for the individual situation, whenever changes occur.

29: In the example on page 4-26 in the User's Manual, is the date at MDS item A3a correct?

A: No. A3a in this example should be dated 09-01-1995. This was previously acknowledged by HCFA and sent out as a correction.

30: What is the significance of item A3b?

A: This item was originally designed to allow for correction in a computer environment. However, HCFA's current correction policy (refer to the RAI User's Manual, page 2-25), does not allow the item to be used. Additional changes may be forthcoming when HCFA's ADP requirements are published.

31: For item A4a on the Quarterly and the Annual Assessment, if a resident has not been hospitalized do we leave the item blank?

A: For both the Full and Quarterly Assessments, if the resident has not been hospitalized in the past 90 days, leave this item blank. The Users Manual reference for this question is on page 3-31.

32: Please define item A7h, "Medicaid resident liability or Medicare co-payment".

A: This is the beneficiary's liability for PART A coinsurance.

33: Regarding the intent of Item C6 - Ability to Understand Others: Is writing an acceptable substitute for verbal communication?

A: Yes. According to the intent as described on page 3-53 of the RAI Version 2.0 User's Manual, information may be communicated to the resident orally, in writing, or in sign language or Braille. When coding the item, be sure to follow the processes described on page 3-53. The resident may definitely be able to understand others when the information is presented to the resident in a way that he or she is most able to receive it. However, not all persons who interact with the resident will share information in the same way. If the resident needs to receive information in writing because he is highly hearing impaired but others (e.g., a roommate, visitors, other residents, etc.) do not present the information in writing, you must take this into consideration in coding the response that best reflects the resident's objective ability to understand information as it is presented to him.

34: Under Section E1, if "verbal expression" occurs five times during 30 days, but not daily, how is it coded?

A: The answer to this question is "1". By definition, code "2" applies to daily, or almost daily behavior. The User's Manual reference for coding this question is on page 3-60.

35: If a resident was showing signs of depression for six days in one week (but less than six days for each of the other weeks during the 30-day period), how would I code Section E1?

A: The behavior in this example would be coded as "1". For more coding information, refer to the response to the previous question.

36: Should the response to MDS item E4e, "Resists Care" include instances where the resident exercised his/her right to refuse treatment?

A: No. The item includes resistance to taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to re-institute treatment). Refer to the User's Manual, page 3-63.

37: "Change in Behavioral Symptoms", MDS item E5, asks for a comparison to behavioral status 90 days ago. Does this comparison include the entire 90 day period, or a snapshot of today versus a one-day snapshot of 90 days ago?

A: Item E5 asks for a snapshot of "today" as compared to 90 days ago (i.e., a comparison of two points in time). The intent of the item is to document whether the behavioral symptoms or resistance to care exhibited by the resident remained stable, increased or decreased in frequency of occurrence or alterability as compared to the resident's status of 90 days ago. By definition, this refers to the status (new onset, improvement, worsening) of any of the symptoms described in item E4. If the resident is a new admission to the facility, review changes during the period prior to admission and score the resident at the time of the observation period, as compared to the resident's status 90 days ago. Refer to the User's Manual, pages 3-66 through 3-68. Behavioral symptoms for the entire 90 day period should be reviewed however, for care planning purposes.

38: Why do F1b, "Establishes own goals" and F3a, "Strong identification with past roles and life status" trigger the Psychosocial RAP?

A: Both are new as trigger elements and were added in response to providers and consumer advocacy groups' desires to use the triggers to help staff focus on areas of resident strengths. This helps in staffs' efforts to assist the resident reach his or her highest practicable level of well-being. Data indicated that triggers needed to be more inclusive for this RAP.

39: Regarding MDS items F2 and F3, the guidelines in the User's Manual on page 3-70 (process paragraph) state to observe "over the past seven days". This was not stated for MDS item F1. The observation periods for F1, 2 and 3 are not noted on the MDS. Please clarify the expected observation period for F1.

A: Items for which observation periods are not specifically listed on the MDS are always 7 days. Use "over the past seven days" as the observation period for F1. This is stated in the "process" paragraph on page 3-69 in the manual.

40: Regarding the concept of weight bearing support in Item G1A (ADL Self-Performance), Code "3", Extensive Assistance: Does weight bearing support refer to staff "taking some of the resident's weight?"

A: Yes.

41: How should items G1e and f, (pertaining to locomotion on and off unit), be coded for a resident who propels his wheelchair, but does not make it to a destination without assistance?

A: Code the items according to the amount and frequency of assistance received, using the ADL Self-Performance and Support code instructions provided in the User's Manual, Section G.

42: If a resident is bed bound and does not walk, do you code them as an "8"?

A: Assuming this question is in reference to Section G, items 1e and 1f (locomotion on and off the unit), the User's Manual reference for this response begins on page 3-73. If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code as "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G., 1A & B. If this question refers to G1c and 1d (walk in room/corridor), code as an 8.

43: Is standing balance (MDS item G3a) coded for standing only? How is the item coded for residents who can stand, but who cannot get to a standing position without physical assistance?

A: Refer to the User's Manual, page 3-91. "DO NOT attempt to test residents who cannot stand by themselves". Code these residents as "3", "Not able to attempt test without physical help".

44: Can a Restorative Aide do the testing necessary to code items G4 (A) and (B)?

A: No. A therapist or nurse should conduct the evaluation.

45: Regarding G4 (A), "Limitation in Range of Motion", in the example in the User's Manual on page 3-98, the resident has a bilateral limitation in neck range of motion, yet the item is coded "1", which is defined as a limitation on one side of the body. Is this correct?

A: This example contains a coding error. The item should be coded "2", limitation on both sides of the body.

46: The coding instructions for G4 (B), "Loss of Voluntary Movement", on page 3-98 of the User's Manual do not include a coding option for a resident who has full loss on one side of the body, and full range on the other. How would this be coded? Also, how should we code for partial loss on one side and full loss on the other?

A: Code both situations "1" for Partial Loss of Voluntary Movement.

47: Regarding Section G, item 4cB, how do you code a resident who has arthritis in both hands, but is able to dress self?

A: There is not enough information provided to code the question. A diagnosis of arthritis does not necessarily impact function. To determine the code, you must consider two parameters: completion of the task (i.e., not interfering with daily functions) and coordination of movements. You have already determined that the resident is functionally able to complete the task of self-dressing, which would rule out code 2. If the resident has full ROM in both hands, use code 0. Next determine coordination of movements: select code 0 if the resident's movements were smooth and coordinated; code 1 if the resident's movements were slow and uncoordinated. Refer to the coding instructions in the User's Manual on page 3-98.

48: Regarding Section G, explain the intent of code 8, particularly regarding walking and eating.

A: Code 8 is reserved for use when an ADL did not occur in the 7 day observation period. For example, use

code 8 when the resident did not walk in the past 7 days, (in room/in corridor), for both the self performance and the support columns. Refer to the guidelines, definitions and examples in the User's Manual, beginning on page 3-73.

The eating item for G1h, is a little more complex. If in the past 7 days the resident truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as 4, rather than 8.

49: When is code 8 appropriate for ADL items?

A: Code 8 means the activity did not occur in the past 7 days. A resident who has not been out of bed in the past 7 days could be coded 8 for (A) & (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADL's are considered individually. Refer to the ADL coding guidelines in the User's Manual on pages 3-77 through 3-82. Also refer to the bottom of page 2-24.

50: If a resident lacks all ability to perform ROM (range of motion) exercises on request due to impaired cognition, and has no limitations in ROM, how should G4a & b be coded? A Physical therapist told me that active assistive ROM cannot be done with mentally impaired residents because they cannot follow the instructions the User's Manual suggests.

A: This is a good question because many residents in nursing facilities are cognitively impaired. These items are coded based on the resident's ability to perform range of motion and voluntary movement. For G4a, a resident who is unable to follow your verbal instructions or a demonstration of movements can be actively assisted in range of motion exercises to assess for limitations. Move the resident's joints through slow, active assisted ROM by providing support and direction with each activity. In this section, you can also use observations, by the staff, of what the resident can do. Refer to the User's Manual, page 3-96.

51: How would item G4, column B be coded for the example in the User's Manual on page 3-97?

A: There is not enough information to score G4 in this example. The assessor would have to utilize available information pertaining to the individual resident in order to score this item.

52: When a resident cannot/does not have voluntary ROM due to impaired cognition, yet at other times, strikes out or makes movements considered ROM, how is this coded?

A: You can use staff observations of the ROM activity to determine whether a resident can actually perform the activity, regardless of whether the movement was "on command", provided the movement fits the criteria on page 3-96 of the User's Manual and occurred during the assessment period of observation.

53: Regarding Section G4, when assessing Functional Limitations in Range of Motion, how are amputations coded?

A: Section G focuses on two areas of resident ability: (A) Range of Motion, and (B) Voluntary Movement.

The coding scheme is the same for both items. If the resident has an amputation on one side of the body, code "1". If the amputation is bilateral, code "2". Refer to the User's Manual, pages 3-97 and 3-98.

54: How do you accurately assess cognitive status for an aphasic resident?

A: It is often difficult to accurately assess cognitive function, or how someone is able to think, remember, and make decisions about their daily lives, when they are unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a resident and hear responses from them that give you clues to how the resident is able to think (judgement), if he understands his strengths and weaknesses (insight), whether or not he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia).

To assess an aphasic resident it is very important that you hone your listening and observation skills to look for non-verbal cues to the person's abilities. For example, for someone who is unable to speak with you but seems to understand what you are saying (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident.

In all cases code the cognitive items with answers that reflect your best clinical judgement, realizing the difficulty in assessing residents who are unable to communicate. Items B1, B4, B5, and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment. See pages 3-44 and 3-48 of the User's Manual for instructions.

55: Are gerichairs or merry walkers included in Section G5? How do you code these?

A: Merry walkers can be included in G5a because they are a type of walker. Gerichairs are not captured here because this section is looking at modes of locomotion that the resident is using. Gerichairs are considered a stationary vehicle.

56: In Section G6a, what if the resident spends all of his time in bed or is in a recliner chair for 22 hours a day but is out of his room in another part of the facility? Is the location of the bed or recliner a crucial point?

A: In this case, the location of the bed or recliner is the crucial point. Assess the resident's mode of transfer in his/her own room. If the resident is out of his room for most of the day, you would not check G6a. The User's Manual reference for this question in on page 3-99.

57: Section G6b assesses whether "Bed rails are used for bed mobility or transfer". In P4a, the item documents whether full bed rails are used in a section entitled "Devices and Restraints". Will this identify enablers as restraints on the HCFA 672?

A: Section P4 identifies whether full or partial side rails are used, but does not make a judgment regarding

whether they are used as a restraint. When the siderails are used to assist in mobility and item G6b is also checked, then for the purpose of completing the HCFA 672 form, G6b minus P4a&b identifies restraints.

On the HCFA 672, a form used to document resident characteristics during a LTC facility survey, item F 104 is completed by the facility to identify the number of physically restrained residents in the facility at the time of the survey. The State survey team could use this as one piece of information in selecting a sample of residents for in-depth review during the survey. It offers a screening mechanism to determine the extent of restraint use within the facility. This information would need to be developed by the survey team as they investigate their concerns.

58: Regarding Section B1, "Comatose", providers with sub-acute units request a (further) definition of "no discernible consciousness". This would be for situations when there is no documented neurological diagnosis of coma or persistent vegetative state on admission; however, the resident, as assessed by the interdisciplinary team, has "no discernable signs of consciousness".

A: Coma is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he does not open his eyes, does not speak, and does not move his extremities on command or in response to noxious stimuli (e.g., pain).

Sometimes patients who were comatose for a period of time after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they have extensive damage to both cerebral hemispheres. This state is different from coma and if it continues is called a persistent vegetative state. Both coma and vegetative state have serious consequences in terms of long-term clinical outcomes and care needs.

Many other residents have severe impairments in cognition that are associated with late-stages of progressive neurological disorders such as Alzheimer's disease. Although such residents may be non-communicative, totally dependent on others for care and nourishment, and sleep a great deal of time, they are usually not comatose or in a persistent vegetative state as described above.

To prevent any resident from being mislabeled as such it is imperative that coding in MDS Item B1 reflect physician documentation of a diagnosis of either coma or persistent vegetative state.

59: Should intraocular lens implants (IOL's) be documented under Vision Patterns, Section D, or Disease Diagnoses, Section I? It's not a disease, as the cataract has been removed. Basically, it's an inactive diagnosis.

A: Section D of the original MDS was revised so that lens implants are no longer captured in Version 2.0. The presence of an intraocular lens implant should still be included in the resident's physical assessment and documented elsewhere in the resident's clinical record, for example: under ophthalmology.

60: Regarding Section G, ADLs, in interpreting toilet use, under what circumstances would it be appropriate to use code 8? Does toileting strictly refer to the resident being in the bathroom?

A: No, this item focuses on whether elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment.

The "8" code is rarely used in this section, as it would indicate that elimination did not occur. The User's Manual reference for this question is page 3-108 and 3-109.

61: If a resident displays a behavior prior to and after, but not once during the 7-day period of observation, would you still work the related RAPS?

A: If a behavior does not occur within the MDS observation period set by the assessment reference date in Section A3, do not code it on the MDS. The fact that the resident did not display a known behavior during the observation period does not mean it can be ignored. For episodes of behavior that occur outside the observation period, clinical judgment should be exercised regarding whether RAP review and care planning are clinically warranted and the type of documentation that is appropriate.

Questions on Items in MDS Sections H through R

62: How should Bladder Continence, item H1b, be coded for a resident who dribbles urine frequently and wears an incontinent pad, but changes the pad herself, and her underwear is never wet?

A: Bladder continence refers to control of urinary bladder function, which is distinct from the resident's ADL status and need for assistance during toileting. Proper coding of this item requires review of the number and frequency of incontinence episodes over the 14-day review period. With that information, code the continence level according to the 5 point scale in the User's Manual on pages 3-106 and 107.

63: On the Quarterly Review form in Section H2 - Bowel Elimination Pattern, why are there only two answer options: Fecal Impaction or None of the above?

A: Not all MDS items appear on the Quarterly Review form. In this case, the Quarterly Review was planned to look for sentinel events. Items a) Regular bowel elimination, b) Constipation, and c) Diarrhea, were not considered. In one year, one State reported deaths of five nursing home residents, with the cause of death linked directly to fecal impaction. In this case, "none of the above" is checked if fecal impaction did not occur during the assessment period of observation.

64: Regarding item H4, for a resident who had a catheter and was coded as continent on the last MDS, but 90 days later has had the catheter removed, is on a bladder retraining program but is leaking urine during the new observation period, is the MDS coded as "improved" or "deteriorated"?

A: Code as "deteriorated". The issue is performance. Refer to the explanation and examples in the User's Manual, beginning on page 3-105.

65: Regarding Item H4, Change in Urinary Continence: If a resident's condition has changed from

dribbling urine without an indwelling catheter to dry with a catheter, would this be coded as "1", Improved?

A: Yes. According to the User's Manual on page 3-110, "Although one could perceive that [the resident] had deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed." The key issue in coding MDS items is "objective performance". In this case, the resident is continent and therefore coded as "improved," even though the catheter is the basis for the change in status.

66: Regarding Section I, item 1, all diseases are linked to an alpha character, in alphabetic order from a to rr. On the expanded Quarterly form, diagnoses are not in alphabetic order. Should the order on the form be changed to conform to the data dictionary?

A: No. Each item is associated with its respective label on both the full MDS and the expanded Quarterly Review form. The alphabetic order of the items is not as important as having consistent item labels.

67: Regarding HIV Confidentiality: Does staff need authorization to get information to complete I 2d? What about transmitting the information?

A: HCFA has treated the item for HIV infection the same as for other clinical diagnoses. Refer to the State regulations for guidance. Additional information regarding submission of this data element will be forthcoming with publication of HCFA's pending regulations on MDS automation. All such clinical information is considered confidential and protected as a part of the resident's clinical record.

68: Sensitive issues related to HIV infection and sexually transmitted diseases are documented on the MDS (I2d & I2h). Our State agency policy requires facilities within our State to omit documentation for these 2 items. What are we to do?

A: If a State has a policy that covers this, the State policy supersedes the MDS requirement.

69: Pneumonia and respiratory infections are both mentioned in Item I2. How do we work through this to code correctly?

A: Review the definitions on page 3-116 of the User's Manual. A key point according to the manual is that a "respiratory infection is any upper or lower (e.g., bronchitis) respiratory infection other than pneumonia". If the resident has only pneumonia, check only item I2e, rather than both I2e and I2f.

70: Are infections to be documented in Item I2 only if they have occurred in the past 7 days?

A: According to the directions for Section I, Disease Diagnoses, "Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)." Therefore, if the resident has an infection that is currently active and impacts on one of the above areas, check the appropriate response. This category includes conditions that occurred prior to the past 7 days but are still actively treated. The exception is Item I2j, Urinary tract infection in last 30 days. If the resident had a urinary tract infection during this time frame, check Item I2j, even if the resident no longer received treatment or monitoring for the condition during the

assessment period.

71: What information is entered on the MDS if staff are unable to obtain a resident's weight?

A: There may be circumstances under which a resident cannot be weighed, for example: extreme pain or immobility, risk of pathological fractures or extreme obesity. If, as a matter of professional judgement, a resident cannot be weighed, use the standard no-information code, which is either a "circled" dash or an "NA". Refer to the User's manual, page 2-24 for further information regarding coding when information is not available.

72: For Section K, are there any regulations or guidelines related to desirable weight gain or loss time frames? How much weight loss in what period of time is considered too fast?

A: There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F 326) and 483.20(b)2(v), resident assessment nutritional status and requirements (F 272), which corresponds to the MDS Section K, Oral/Nutritional status.

The parameters for weight loss identified in the guidelines referenced above are:

1 month 5% significant >5% severe

3 months 7.5% significant >7.5% severe

6 months 10% significant >10% severe

The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process. An adequate assessment should result in a "comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs."

73: In Section K, is documentation required for 7 1/2% significant weight change in 90 days?

A: Yes. This change is recorded in K3a only when there is a minimum weight loss of 5% or more of total body mass over 30 days, or a 10% or greater loss over 180 days. In this example, scoring of K3a would depend on how much of the 7 1/2% weight loss occurred over the last 30 days. Documentation of the identification and evaluation of weight change is good clinical practice. The significance of the weight change for that resident should be reflected within that documentation.

74: Regarding item K2b, "weight", the entry field doesn't allow for fractions of a pound. How is this accounted for on the MDS? Also, how is a fraction of a pound handled when calculating weight change?

A: For purposes of completing item K2b on the MDS, round the resident's weight up to the next pound. Also round up to the next pound in calculating weight change.

75: Why are there two weight change questions on the MDS? Are questions K3a and b the same?

A: Item K3a captures weight loss; K3b captures weight gain.

76: We use hypodermoclysis and subcutaneous ports in hydration therapy. Should we code these nutritional approaches in Item K5a, Parenteral/IV?

A: Yes. Although it is not defined in the User's Manual, the term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Item K6a and K6b which refer to the caloric and fluid intake the resident received in the last 7 days.

77: How is the presence of a gastrostomy coded?

A: Code a gastrostomy tube at item K5b, under Nutritional Approaches. A gastrostomy tube would meet the definition for Feeding Tube, "any type of tube that can deliver food/nutritional substance/fluids/medications directly into the gastrointestinal system". Refer to the User's Manual, page 3-130.

Also refer to page 3-149 regarding Section P1f, (special treatments, procedures, and programs) response f for "ostomy care." This item focuses on the care and treatment a resident with an ostomy receives.

78: Regarding Section M, "Skin Condition": Since the response holds only a single digit, what is the appropriate code for a resident having more than 9 pressure ulcers? If the resident has more than 9 areas, how would you know the exact number of pressure areas?

A: Your particular question only applies if there are more than 9 ulcers at any one stage. If so, use code 9 for nine or more. Refer to the coding instructions in the User's Manual on page 3-135.

The MDS response regarding the number of ulcers is determined by physical examination of the resident. Staff should not rely solely on the MDS for information concerning pressure ulcers. The number and stages of ulcers could change shortly after the MDS is completed, and the MDS, in itself, does not include enough information to support the on-going care and evaluation of pressure ulcers. Documentation of clinical information pertaining to the number, size, description, care and the resident's response to treatment of pressure ulcers should be maintained in the resident's clinical record and updated on an on-going basis.

79: Are ankle problems to be included in Section M6, "Foot Problems and Care"?

A: No. The ankle is the joint between the ankle and the foot, and is not included here.

If you are dressing the foot as well as the ankle, code the foot issues in M6 and code the ankle issues in M5h and M5i.

80. Regarding item M1, "Ulcers", how should a pressure ulcer that is eschared, necrotic or blistered be staged?

A: Code it as stage IV in terms of using the MDS scale. However, HCFA acknowledges that the NPUAP has recently published guidelines for pressure ulcer staging, and will be investigating this area in the future.

81: Regarding MDS item M6d, "Nails/Calluses trimmed during the last 90 days", and the guideline in the User's Manual on page 3-140 that includes trimming by a nurse or any health professional, including a podiatrist, is a CNA considered a "health professional" for the purpose of coding this item?

A: No. The item is intended to capture licensed professional time.

82: Current literature on staging pressure ulcers suggests that stage 4 ulcers which are healing cannot be characterized as stage 3, stage 2, and stage 1, as they are healing. The alternate approach is to identify the ulcer as a healing stage 4 ulcer. Consultants and providers are very upset that they have spent the past year training personnel how to stage ulcers in this manner, but the MDS encourages them use a reverse staging system. Can we have resolution? For example, is a healing Stage 3 Pressure Ulcer coded as a 3 or 2?

A: Code it as a 2. For the MDS Version 2.0, code the ulcer in terms of what you see (i.e., visible tissue). That is, the MDS should be coded the way it was in the original version. Currently, there is no uniform Nomenclature or scoring system approved for coding a healing pressure ulcer. In the clinical record, describe the appearance of the healing ulcer (i.e., presence of granulation tissue, size, depth, color, and so forth). Pressure ulcers are coded on the MDS as they are currently seen, as per the instructions in the Long Term Care RAI User's Manual Version 2.0, Oct. 1995.

83: Is time spent involved in independent, unstructured leisure activity, (for example: watching favorite soap operas, talking on the phone, knitting), to be included in "average time involved in activities"?

A: Yes. Include time spent in pursuing independent activities, (e.g., watering plants, reading, letter-writing); social contacts (e.g., visits, phone calls) with family, other residents, staff, and volunteers; recreational pursuits in a group, one-on-one or on an individual basis; and involvement in therapeutic recreation. Refer to the User's Manual, page 3-141. Keep in mind that the definition of "activity pursuits" refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. Efforts should be made to provide activities suited to the resident's preferences and capabilities.

84: Section N, item 2 is not clear; does this mean while awake or involved in activities?

A: Item N2 refers to the amount of "free time" a resident has while awake and is not involved in receiving nursing care, treatments, or engaged in ADL activities, and could therefore be involved in activity pursuits and therapeutic recreation of their choice. This item has a 7-day observation period, which should give an accurate indication of the resident's activity involvement pattern. Refer to the User's Manual, page 3-141.

85: Regarding item N2, "Average Time Involved in Activities", is it accurate to say that cognitively impaired residents would likely be coded as having little or no involvement (based on available time), since they are lacking the ability to consciously "pursue" their interests?

A: No. Many cognitively impaired persons continue to "pursue" their interests and also develop new interests. Activities must be tailored to their cognitive abilities. Record the amount of time the person spends in structured and non-structured activities. Refer to pages 3-140 to 3-142 of the User's Manual, which includes a broad definition of activity pursuits.

86: Where would you record a preference for activities such as trivia games, intellectual groups or party-type activities?

A: If the activity is predominantly a social-type activity then record it under N4k. If the activity is more "game-like" in nature, then record it under N4a. The MDS does not provide a separate item to document resident's preference for every possible type of activity. Coding decisions should be based upon the predominant overall nature of the activity. Refer to the User's Manual, page 3-142.

87: Define Activity "pursuits" vs: "programs", and how the assessment guidelines distinguish between what the resident prefers, and what the facility offers.

A: N4 refers to resident activity preferences (adapted to the resident's current abilities). N5 determines if the resident is interested in activities that are either not offered, or are offered but not available to the resident. Refer to the User's Manual, pages 3-142 & 143.

88: Regarding item N2, "Average Time Involved in Activities", is time spent eating to be included in the calculation of time available for activities? In other words, is dining considered an activity?

A: Although dining is a social experience for some residents, and at times, meals may be planned around certain events or occasions, eating is not to be counted as an activity. Available time for activities refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities (including eating) and could have been involved in activity pursuits and Therapeutic Recreation. Refer to the User's Manual, page 3-141.

89: Regarding MDS items N3 and N4, when the resident is marginally responsive and family is not available, what is the most appropriate method of gathering information concerning "Activity Pursuit Pattern"?

A: Explore other possible sources of information, such as a responsible party that admitted the resident into the facility, or a surrogate decision maker who might know the resident's preferences. Is there any useful information in records that precede admission to the facility, such as hospital, community or home care records? If all resources are exhausted and you still do not have information, code the responses as information not available, (see the User's Manual page 2-24). Also, as noted in the User's Manual on page 3-143, observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program), check the item on the form.

90: If a resident receives more than one type of insulin, is each type recorded in MDS item O1?

A: Yes. For example, Lente, Humulin, and Regular are different types of insulin and are considered different medications.

91: Is Sustacal or any nutritional supplement considered a medication as it relates to MDS Section O?

A: Section O is designed to capture data concerning the use of over-the-counter and prescription medication. The User's Manual, on page 3-145, expands the definition of medications to include topical preparations, ointments, creams used in wound care (e.g., Elase), eye drops, vitamins, and suppositories. Although the pharmacy sometimes supplies such items, Sustacal is not counted as a mediation for coding in Section O. Vitamins should be counted (as noted above). The Sustacal could be recorded in Section K5, provided it fits the definitions.

92: In Section O, Medications: Why doesn't a hypnotic drug trigger the Psychotropic Drug Use RAP?

A: Hypnotic drug use does not add any discriminating ability in terms of identifying residents who warrant additional assessment.

93: In Section O1, "Number of Medications", are B12 injections that are given once per month, but outside of the assessment period included (as are the long acting antipsychotics illustrated in the User's Manual)?

A: Yes. If the resident received an injection of Vitamin B12 prior to the observation period, code in Section O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics.

94: Where should we code suppositories administered as part of a continence/bowel program?

A: Record suppositories in Item O1, Number of Medications. For facilities in States using Section U, also record in Section U.

95: Are suppositories, enemas, fleets, and glycerin to be included in Item O1, Number of Medications?

A: Of this list, only suppositories are to be coded in Item O1.

96: In Section O3, "Injections", would this include B12 injections given once per month but outside of the observation period?

A: No. In O3, code only the injections administered during the observation period.

97: Regarding item O4, should over-the-counter sleeping medications be coded as hypnotic even though they are not pharmacologically classified as hypnotic drugs?

A: No.

98: Regarding item O4, one facility has a resident receiving Serax, classified as an anxiolitic drug, specifically for sleep. Should this drug be coded as a hypnotic because of its intended use?

A: No. Although in practice Oxazepam (Serax) may be used as a hypnotic, it is classified as an antianxiety (anxiolitic) agent in Appendix E of the User's Manual, and should be coded as such. Code the MDS according to the drug's pharmacological classification, not how it is used. This enables monitoring of side effects

associated with the drug.

99 Regarding item P4e, "Chair Prevents Rising", the User's Manual, page 3-158 includes as an example a chair with a lapboard that locks. Is a chair with a lapboard that does not lock also considered a "chair prevents rising"?

A: A chair with an unlocked lapboard could be included as a chair prevents rising if the resident cannot easily remove the lapboard. It is also considered a restraint if the chair prevents rising for the resident who ordinarily could rise. If the resident can remove the lapboard and can rise from the chair, do not code P4e.

100: In Section P, Intake and Output, would this include daily I and O for residents receiving tube feeding or short-term IV fluids?

A: Yes. Intake and output includes "all" fluids the resident received and/or excreted for at least three consecutive shifts during the 14-day period of observation. Refer to the User's Manual, page 3-149.

101: Regarding Section P1, item a, r, "Training in skills required to return to the community", does this training include that provided as part of Occupational Therapy, Physical Therapy, and Speech Therapy?

A: Yes.

102: In Section P1f: Does "Ostomy" refer to any and all ostomies (except tracheostomy) that require nursing assistance for care, e.g.: gastrostomies as well as colostomies, urostomies, etc?

A: Yes. The User's Manual reference is on page 3-149.

103: In Section P1 - Is whirlpool included in Physical Therapy services?

A: If whirlpool is specifically ordered by the Physician to be done under the supervision of the Physical Therapist, it is included in that service.

104: Regarding Section P 2, "Evaluation by a licensed mental health specialist", please define "psychiatric social worker". Our State does not have a definition of this term in our practice guidelines.

A: Each State licenses independent providers of mental health services who can provide care in the facility, at home, office or clinic. The term "psychiatric social worker," (synonymous with clinical social worker) refers to someone with training in clinical mental health practice who is qualified to practice as a psychotherapist. Depending on State licensure requirements, a psychiatric/clinical social worker functions as an independent practitioner or under consultation, usually to a psychiatrist.

105: Should we define psychiatric nurse credentials? Can this include LVN/LPN? And what about credentials for Psychiatric Technician?

A: Psychiatric nurses usually have a Master's degree and/or certification from the American Nurses

Association as a psychiatric specialist. Psychiatric Technicians do not fall under this category.

106: How is MDS item P2b, "Evaluation by a licensed mental health specialist in the last 90 days", coded in States where mental health workers are not required to be licensed?

A: If your State doesn't license a certain category of therapists, then do not count it at item P2b.

107: Regarding Item P1b, if one Physical Therapist has a group of 5 residents in an activity, does each resident get the full value of the therapist's time, or is that time shared among members of the group?

A: Generally, in a group larger than 4 residents, the residents are receiving supportive services, not treatments, unless there are at least 2 staff persons with the group. For the most part, the therapy services section assumes individualized treatment and the category does not include services received as part of a group of more than 4 residents per supervising helper (as stated in the Nursing Rehabilitation section on page 3-154 of the User's Manual). If, however, the group has four or fewer residents per supervising therapist (or assistant), give each resident the full time value spent in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy. Remember, code for the resident's time, not for the therapist's time.

Also, the service must meet all of the following criteria to be coded in the therapy section:

C The service must be ordered by a physician.

C The therapy intervention must be based on a qualified therapist's evaluation and plan of care as documented in the resident's record.

C An appropriate licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing services.

108: When looking at time for PT, OT or Speech, do we consider direct resident contact time only? For example, if you set a resident up for a treatment, is the entire time of the treatment counted or only the start/stop time required by the professional?

A: The MDS 2.0 measures the resident's characteristics and services received. The amounts of time reported in Section P1b must be the "resident's time in treatment," not the time and effort of the staff to produce and document the treatment. The resident's treatment time starts when he begins the first treatment activity or task and ends when he finishes with the last apparatus and the treatment is ended. Set-up time is also included. In some cases, the resident will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the resident is a part of total treatment time. For example, as the last treatment task of the day, a resident uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the resident up on the apparatus. This therapist or assistant under the supervision of a PT may then leave the resident to help another resident in the same exercise room. However, the therapist still has eye contact with the resident and is providing supervision, verbal encouragement and direction to the resident on the bicycle. Therefore, if it took 2 minutes to set the resident up with the cycling apparatus, the resident was supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and

took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the resident did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the MDS is 60 minutes. The key is that the resident was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process.

109: Does therapy provided by Recreation and Art therapists count as Psychological Therapy in answering item P1be?

A: No. Psychological therapy is provided by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse or psychiatric social worker. Refer to the User's Manual, page 3-151.

110: Regarding MDS item P1bd, "Respiratory Therapy" and the guidelines in the User's Manual on page 3-151, ...[therapy] provided by a qualified professional, (i.e., trained nurse, respiratory therapist); what is the definition of a "trained nurse"?

A: "Trained Nurse" refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses may not necessarily learn these procedures as part of formal Nursing training.

111: Do breathing treatments given by a nurse count as a respiratory treatment?

A: Respiratory therapy can include coughing, deep breathing, heated nebulizers, aerosol treatments, mechanical ventilation, etc., which must be provided by a qualified professional (i.e. trained nurse, respiratory therapist). Refer to the User's Manual, page 3-151.

112: When a resident talks to a nurse about emotional problems, does it count as Psychological Therapy in answering item P1be?

A: No. Although this is helpful to the resident, and is a part of good nursing practice, this item is intended to capture Psychological Therapy time, which is specifically provided by a licensed mental health professional. If the conversation occurred as part of a structured therapy session, and the nurse was a psychiatric nurse, it could be coded as Psychological Therapy. Refer to the User's Manual, page 3-151.

113: When a psychiatrist conducts an evaluation, how and where is it coded?

A: The assessment of a mood or behavior disorder, or other mental health problem by a psychiatrist is identified on the MDS in Section P, item 2b (evaluation by a licensed mental health specialist in the last 90 days). Additionally, if the visit occurred in the 14-day period of observation, a psychiatrist's visit is coded in item P7, Physician Visits.

114: What is the difference between a qualified therapist's evaluation (such as Occupational, Physical, or Respiratory Therapist), and a psychiatrist's evaluation in terms of MDS coding?

A: A therapist's (OT, PT, ST) initial evaluation would not be coded on the MDS. However, evaluations done as part of the treatment process would be included in treatment time. A psychiatric evaluation would be

checked in Section P2b, if conducted within 90 days prior to the Assessment Reference Date. An evaluation by a psychologist, psychiatric nurse or psychiatric social worker would be checked in P2b.

115: Our facility has Physical Therapists evaluating the residents on a weekly basis. Can the Therapist's evaluation of the resident's ROM be substituted for an evaluation by a licensed nurse, for the purpose of completing Section P3?

A: Section P3 addresses Range of Motion exercises provided as part of nursing rehabilitation restorative care. The definition specifically states that it does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b. Periodic evaluation of ROM, unless done as a part of a treatment program, does not count.

116: Regarding P3a, b and c, "Nursing Rehabilitation/Restorative Care", if in the same shift a resident is provided 11 minutes of Passive ROM, 11 minutes of Active ROM, and a splint is applied, which takes 5 minutes, can the total of 27 minutes be combined in a single MDS response?

A: No. Passive ROM, Active ROM and splint/brace assistance time must all be coded separately, in time blocks of 15 minutes or more. For example, in order to check item P3a, 15 or more minutes of Passive ROM must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on day shift plus 5 minutes in the evening). However, 15-minute time increments cannot be obtained by combining P3a, b and c. Refer to page 3-155 of the User's Manual.

117: Regarding MDS items P3a & b, the guidelines on page 3-154 include a definition of Active Range of Motion, but not of Passive Range of Motion. At some time, will a definition of Passive be added? What is the definition of Passive Range of Motion to be used in completing these MDS items?

A: Passive Range of Motion exercise - The care giver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. Code under P3a.

118: Regarding MDS item P1b, does the therapist have to complete and sign off for this section, or can the RN Coordinator complete it after obtaining information from therapy?

A: This item may be completed directly by the therapist, or the therapist may document this information elsewhere in the record or otherwise share this information with another staff member (such as the RN Coordinator), who then documents this information on the MDS. If the RN Coordinator documents the information on the MDS, she must make sure that the therapist understands and uses the MDS concept of treatment time. Federal regulations offer facilities a great deal of flexibility in how the RAI assessment is completed and documented, requiring only that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. Refer to the User's Manual, page 2-16.

119: Regarding Section P, if a small group (4 residents or less) participate in an activity consisting of the resident's applying make-up, and which conducted by a member of the activity staff under the restorative nursing program with goals, objectives and documentation of progress, could it be

included in Section P3g, (grooming)?

A: Yes. Refer to the User's Manual, page 3-153 for the definition of Rehabilitation/Restorative Care, and page 3-154 for the list of criteria that (all) must be met in order to be included in P3. According to the criteria, other (non-nursing) staff or volunteers may be assigned to work with specific residents, under licensed nurse supervision.

120: Some restraint-specific assessment forms duplicate information collected on the MDS. Must a restraint assessment be done in addition to the MDS?

A: In response to this specific question, the assessment for restraint use could be documented in the record in a non-standardized manner or it could be conducted using a specific form to guide the assessment. The facility may choose whatever format they like, but as the RAI is already required, it makes sense to integrate the forms and thereby minimize unnecessary duplication. If physical restraints are triggered on the Trigger Legend, proceed to the Physical Restraint RAP. Medical symptoms warranting restraint use (chemical or physical) must be reflected in the clinical record. In most instances, it is expected that the facility should engage in a systematic and gradual process toward reducing restraints simultaneous with restorative/rehabilitative care. Refer to 42 CFR 483.13 (a).

121: If a resident has used a gerichair for over a year without adverse effect, do we need to continue to care plan for restraints?

A: Care planning is an ongoing process which requires the interdisciplinary team to develop, implement and evaluate individualized interventions, treatments and therapies for a resident. A resident's need for an intervention may or may not change over time. This determination can only be made through assessment, reassessment, and evaluation.

122: Regarding item P4, "Devices and Restraints", should the facility code this section regardless of whether the device/restraint is an enabler?

A: Yes. If bed rails are used for mobility aids, refer to G6b on page 3-99 in the User's Manual. Please write this cross-reference guide in your User's Manual on page 3-158.

123: Regarding item P4, "Devices and Restraints", are facilities to code only those restraints or devices that staff consider to be restraints?

A: No. Code all restraints and devices that are used. Use the same logic applied throughout the MDS for "objective performance." In this case, a particular device is being used by the resident; the item does not ask the assessor to evaluate why the device is being used.

124: In Section P4, are side rails coded as a restraint even if they're ordered at the resident's request, and the resident could call to have them released?

A: Yes. Depending on the frequency of their use, siderails would be coded as 0, 1 or 2. In this section, objectively code any device or restraint that was used during the last 7 days.

125: How are facilities in which the call light system and bed control mechanisms are contained within the bed rail to code Section P4, "Devices and Restraints"? Residents in these types of beds generally have the bed rails up. However, the railing may be up to allow the resident to adjust the bed or use the call light. How would this be coded if the resident had full side rails up daily?

A: Section P4, "Devices and Restraints", assesses the objective presence of devices and restraints. A resident who is in a bed with full side rails up on a daily basis is coded in P4a as "2". Also refer to the Question & Answer regarding G6b "Bed rails used for bed mobility and transfer".

126: Regarding item P4e (chair prevents rising), for a resident with a J-tube, who is unable to voluntarily move and is positioned in a gerichair-chair on a daily basis, is the geri-chair coded as a restraint?

A: Assess the objective presence of devices and restraints listed on the MDS. In this case, the resident is in a chair that prevents rising on a daily basis. Code P4e as a "2". Once coded, staff should assess why they are using the gerichair and its impact on resident functioning. The device may actually be an enabler, rather than a restraint, but the care planning needs will be similar (e.g., skin, toileting, fluids, etc.).

127: We were informed that a merry walker was not considered a restraint on a particular resident. Is this a judgment call, or is a merry walker always considered a restraint?

A: Merry walkers can be very helpful mobility devices for some residents. For others however, (e.g. for residents who wander), merry walkers may be a restraint. Staff should code merry walkers in G5a (walker) as well as P4e (chair that prevents rising). Staff would then assess necessity during a review of the Restraint RAP. This logic is similar to that used for bed rails in terms of whether they are considered as enablers or restraints.

128: Exactly how should 3/4 siderails (up x2) be coded?

A: Full bed rails are defined as "one or more rails along both sides of the bed that block three-quarters to the whole length of the mattress". Code for full bed rails. Refer to page 3-158 of the User's Manual. When the siderails are used to assist in mobility and item G6b is also checked, then for the purpose of completing the HCFA 672 form, G6b minus P4 a & b identifies restraints.

129: Item P4 addresses devices and restraints, however, all items refer to restraints. Where do we address assistive/rehabilitation device usage?

A: In Section K5g, "plate guard, stabilized built-up utensil, etc.". Transfer aids, such as a slide board, trapeze, cane, walker or brace are found under G6e.

130: How should item P5 be coded for a resident who has a 23 hour hospital stay and is not admitted? Also regarding P5, in counting hospital overnight stays in the last 90 days, does that include hospital stays in the 90 days preceding admission to the NF?

A: Code item P5 only if the resident is admitted, regardless of length of time away from the facility. If the resident is a new admission to the facility, this item includes hospital admissions during the 90-day period

prior to admission to the NF. Refer to the User's Manual, pages 3-159 & 160.

131: Regarding item P7, "Physician Visits", in addition to the physician types listed in the User's Manual, can the facility count visits made by "Medicine Men"?

A: No.

132: Is it appropriate for therapists to include documentation time in completing items in Section P?

A: No. The MDS 2.0 measures the resident's characteristics and services received. It is not a tool to report "staff effort." The amounts of time reported in Section P1b must be the "resident's" time in treatment. These amounts do not measure the time or the number of staff used to provide the service. This is clearly stated in the User's Manual on page 3-151, "the time should include only the actual treatment time, (not time waiting or writing reports)." The NHCMQ Demonstration has conducted two staff time studies. The 1990 study only collected direct and indirect time. The one in 1995 collected all on duty time of rehabilitation staff including direct (treatment, education and evaluation time), indirect resident specific time (documentation, conferences about individual residents, etc.) and resident non specific therapist time (in-service, travel, administration, supervision of staff, etc.). This information will be used to be sure that non treatment time of therapists, assistants and therapy aides is appropriately accounted for in the payment rates.

133: We're dealing with the issue of whose time to include for therapy. Under what circumstances would time spent by a Rehab Aide be captured as therapy time in Section P1b.?

A: First, note that the MDS 2.0 measures the resident's characteristics and services received. It is not a tool to report "staff effort." The amounts of time reported in Section P1b must be the "resident's" time in treatment. Regarding Physical and Occupational Therapies, Aides cannot independently provide a skilled service, therefore, if there is not a licensed person supervising the Aide, it should not be counted as therapy. Speech Therapy does not currently recognize an Assistant or an Aide as providing "treatment services". Occupational and Physical Therapies credential Assistants and do allow Aides to be supervised by either licensed staff (including contractors), but both Occupational and Physical Therapies, in their professional standards, require that Aides receive intense supervision and therefore, an unsupervised service provided by a licensed Aide should probably be included under Nursing Rehabilitation/Restorative Care in Section P3, rather than under Therapies in P1b. Even when included in Section P3, the Aide providing the service should be supervised.

134: Regarding Section P9, " Abnormal Lab Values", there is no longer a place to code that no lab work was done. Should this be coded as "8" (did not occur) to show that no lab work was done?

A: Enter "0" if there was no abnormal laboratory value noted or if no lab work was done. The "8" code is only for use in Section G.

135: Providers question why lab tests done during hospitalizations, prior to nursing home admissions, are not coded?

A: The MDS is designed to track activity primarily during the nursing home stay, which is used to calculate the resident's case-mix score.

136: Does the discharge potential and discharge plan (Section Q), suffice as the facility's discharge potential evaluation and discharge plan when the resident is not a candidate for discharge?

A: Section Q provides data on discharge potential. Depending on the resident's clinical status and circumstances, additional assessment to determine why the resident is not a candidate for discharge at this time and what plan can be implemented to improve discharge potential may be warranted.

Questions on Items in MDS Sections T and U

137: In the User's Manual, Section T, page 3-169, should "skip to item 3" be "skip to item 2", as noted on the MDS form?

A: Yes. Directions for Section T are correct on the MDS form. The User's Manual, page 3-169 is incorrect, and should read skip to item 2.

138: Regarding Section T, if PT or OT is performed outside the building, (i.e., the facility contracts with an outside vendor for therapy), is the therapy time captured on the MDS?

A: Yes, as long as the staff providing the therapy meet the qualifiers. See SOM Transmittal #272, p. R-64, "The therapy treatment may occur either inside or outside the facility."

139: Regarding MDS item T2b, at some time, will HCFA consider allowing a response for walking less than a minute?

A: This is a special case-mix question for purposes of evaluating residents' progress and making continuing treatment decisions. The reliability and usefulness of this group of items will be evaluated during the demonstration. The results of the evaluation will determine future use.

140: Regarding the second qualifier in item T2, "Physical therapy was ordered for the resident involving gait training (T2b)", is the reference to T2b correct?

A: No. In this area on the MDS form, T2b should be replaced with T1b. You may also wish to make the corresponding change in the User's Manual, on page 3-171. A corrected transitional copy of the form is included with this document and will be formally published by HCFA in a new State Operations Manual.

141: Are services coded in Section P also coded in Section T, or are the Sections mutually exclusive?

A: Code "ordered therapy" in both Sections P and T. The services are not mutually exclusive. Services (OT, PT, and Speech/Language Pathology) coded in Section P as provided should be included in the Section T estimation of ordered treatment time. An algorithm will be developed using items both in Sections P and T for use in a case-mix prospective payment system (PPS). This matter is currently under review by case-mix staff, with further clarification expected when therapy payment is added to the demonstration PPS rate.

142: For facilities using MDS Sections T and U, how often do these sections need to be completed?

A: Sections T and U are required to be completed, if included in the State's RAI, for all Full assessments (Initial Admission, Significant Change, and Annual Assessments). Some States may also require facilities to complete these sections for each Quarterly review. The reference for this question is found in the User's Manual on page 3-1 and page 3-168.

143: Regarding Section U: Are medications taken outside the facility (i.e., at a dialysis center) coded on the MDS?

A: Code only medications on the physician's orders at the facility. If a facility medication order is carried out off premises, (e.g., a dose administered at a dialysis center), that should be included in Section U. As part of communication of care, the facility should probably be aware (e.g., via report) of medication administered at the Dialysis Center without a physician's order on the resident's record at the facility, but there is no item on the MDS to capture this information. Otherwise, dialysis itself is captured in P1 ab.

144: Regarding Section U: Some NDC codes only have 8 digits, not 9. How does this affect entering the codes on the MDS?

A: There should be 9 digits in an NDC code. Check or re-check the source of an 8 digit NDC code to see if a zero might have been dropped. Begin recording the code in the leftmost box on the MDS. Many NDC codes begin with one or more zeros. The zeros are important. Do not omit them. Some NDC codes have 11 digits. In this case, disregard the last 2 digits, (they are package size codes). Refer to the User's Manual, page 3-184.

145: Regarding Section U: If the pharmacy sends a medication for a resident sometimes by brand name and sometimes by generic name (same medication and dose, different NDC), which NDC is coded on the MDS?

A: Code the NDC for the medication that was administered during the observation period. If during the observation period, both the generic and the brand name medications were administered (under the same order), it's up to the facility to decide which to code. For example, the facility may decide to routinely code the generic in such instances. Whatever the decision, it should be carried out consistently. Do not code both, as it would give the appearance of a double order of the same medication. Refer to the User's Manual, page 3-184.

146: Regarding Section U: How is NDC coded when a medication dosage involves 2 separate drug strengths (i.e., with different NDC codes)?

A: If a medication dosage involves 2 separate NDC codes, (e.g., for a physician's order of Coumadin 3 mg., the pharmacy sends (1) 1 mg and (1) 2 mg tablet), code only the NDC for the highest dose. Record the ordered dose, (in this example, 3 mg), in column 1 of Section U.

147: If an oral medication is crushed and administered via G-tube, is the route of administration coded as oral or enteral tube?

A: Use code 9, enteral tube. A note of caution: some oral medications should not be crushed.

148: How are stat doses recorded in Section U?

A: Code as 1 in the PRN column. Refer to the User's Manual page 3-183.

149: Sections T and U are required for Case Mix Demonstration States. Can other States elect to require Sections T and U for facilities in the State?

A: Yes. A request for an alternate instrument for the State should be sent to HCFA, indicating those sections or items the State desires to add to the core MDS (e.g., the State may create a Section S, specify the use of Sections T or U, and add items found in the State RAI to the Quarterly review).

150: Are OTC (over-the-counter) medications to be included in Section U?

A: Yes. All medications received by the resident, including OTC's, should be ordered by the physician and included in Section U. Refer to the NDC List of Common Drugs available from demonstration State project directors, and the World Wide Web site, under the supplemental directory for NDC -- 0296.ZIP.

151: Is it acceptable for a pharmacy printout of Section U information to be attached to the MDS in lieu of completing Section U? If so, what are the specifications for coding/review/signature?

A: A pharmacy printout is acceptable. It is the responsibility of the nurse doing the nursing portions of the MDS to review and verify or correct information, and sign the document. In verifying the accuracy of the report, pay particular attention to PRN medications given or not given in the last 7 days. Medication information needs to be included in data entry for States that submit MDS data electronically. Record specifications for Sections T and U have been developed and published by HCFA. The report itself should be included with the MDS in the resident's active record.

152: Regarding item U5, "PRN-n", are staff to code the total number of doses given in the last 7 days, or the number of days the PRN medication was given one or more times?

A: Record the total number of doses, in the last 7 days, that the PRN medication was given. The corresponding change should also be made in the instructions for #5, PRN-n, in Section U of the MDS form. Refer to the User's Manual, page 1-14.

153: In Section U, page 3-177 of the User's Manual (the last paragraph in the "Definitions" section) reads "...these persons must certify its accuracy with their signature in Section R5". Is this correct?

A: No. In this sentence "R5" should be "R2".

154: The calculated number of minutes of therapy time in the example in the User's Manual on page 3-169 seems incorrect. Please clarify.

A: There was an error. The corrections in this response are in bold type. The last sentence of the first paragraph of the example should read "Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes for a total of 720 minutes in the fifteen days." Also, the bolded sentences at the bottom of this page should read

"Enter "8" in 1c..." and "Enter "720" in 1d".

155: Regarding Section T, in the example on page 3-170 of the User's Manual, the bolded sentences at the bottom begin with "Enter "6" in 2c" and "Enter "360" in 2d". Is this correct?

A: No. Corrections are in bold type. These sentences should read "Enter "6" in 1c" and "Enter "360" in 1d".

Questions Regarding RAPs, Triggers and RAP Documentation

156: Does HCFA have or provide software for facility validation of software trigger logic, (i.e., to check the trigger logic of software purchased from a vendor)?

A: Test files have been developed, which can be imported into the vendor's software, to ensure that triggers have been correctly programmed. This information is available on HCFA's World Wide Web site.

157: Please review the Briggs Trigger Legend format, in comparison to the Trigger Legend in the User's Manual, and comment.

A: The Briggs format is somewhat modified. There are several small changes that do not appear to change the triggering rules.

158: On the RAP Summary form, the directions are to describe complications and risk factors. What is the difference?

A: A risk factor increases the chance of having a negative outcome, or complication. For example, compromised bed mobility increases the risk of a pressure ulcer. In this example, compromised bed mobility is the specific risk factor, and the pressure ulcer is the complication. RAP guidelines may contain cues regarding risk factors and complications associated with the RAP condition.

159: Please give an example of a description of factors that must be considered in developing individualized care plan interventions, as requested on the RAP Summary form.

A: Refer to the RAI User's Manual, pages 4-19 through 4-34, for a detailed case example.

160: Are the RAPs a required component of the RAI process?

A: Yes. Additional assessment is required for each clinical condition (i.e., RAP that triggers). Any triggered RAP must be reviewed as part of the RAI Federal requirements governing the process.

161: On an annual assessment, if a resident triggers the same RAP(s) that triggered on the last comprehensive assessment, is it a requirement to complete the RAP protocol(s) again?

A: Because the same RAP may trigger for a different reason, or for the same reason at a different intensity, or for a reason based on an item not included in the trigger complex prior to MDS 2.0, it's a good idea to review the RAP again. Also keep in mind that even if the RAP triggers for the same reason, (no difference in MDS responses), there may be a new or changed related event identified during RAP review, that might call

for a revision to the

resident's plan of care. The interdisciplinary team determines when a problem or potential problem needs to be addressed in the Care Plan. Refer to User's Manual, page 4-16.

162: When will the new updated RAPs be available?

A: We anticipate the first release of revised RAPs in mid 1997.

163: Must all four factors described on page 4-5 of the User's Manual be present in RAP assessment documentation?

A: Generally yes. RAP assessment documentation should usually describe the nature of the condition and may include presence or lack of objective data and subjective complaints, complications and risk factors that affect the staff's decision to proceed to care planning, factors that must be considered in developing individualized care plan interventions, and need for referrals or further evaluation by appropriate health professionals. However, documentation should be tailored to the condition of the resident. Depending upon the resident's status, RAP documentation does not need to be highly detailed or exhaustive.

164: On the RAP Summary form, the signature at B3 of the "Person Completing the Care Planning Decision" is associated with the date at B4. Is the date at B4 the date when it is decided what to include in the care plan or the date the care plan is completed? And what is to be accomplished by the date at B2?

A: On the RAP Summary form, VB2 is the date that the RN Coordinator certifies that the RAPs have been completed. This date is considered the date of completion for the RAI (i.e., the date used to determine compliance with Federal time frames for assessment and the date that drives future due dates for when the RAI needs to be completed). VB4 is the date on which a staff member completes the care planning decision column, which is done after the care plan is completed. The User's Manual reference for this question is on page 4-18.

165: Is there a format, other than the RAP, to make brief, concise, written commentary to support MDS responses?

A: Documentation systems are largely a matter of facility policy and general practice standards, provided State and Federal requirements are met. Facilities have complete flexibility in determining how to organize their clinical records. Supportive documentation may be kept, for example, in additional assessment worksheets, flow charts, progress notes, the care plan, profile of care, attendance records, or in documentation from outside agencies, such as hospital discharge summaries, lab reports, consultant reports, etc. Facilities may also handwrite information related to MDS items directly on the MDS. The MDS itself is a primary source for describing resident function and in itself may be a primary location for information in the facility. Not every assessment item calls for supportive documentation.

166: On the RAP Summary form, question 4 says to "indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment". In completing column b on the form, how can the type (new, revision or

continuation) be indicated?

A: It is not necessary to indicate the type. Simply check the column if the identified problem is addressed in the care plan.

167: Regarding the RAP Summary form: can the signature lines at VB1 and VB3 be signed by the same person?

A: Yes, provided that person actually completed both functions. It is not a requirement that the same person complete both.

168: Pertaining to documentation supporting RAP decision-making, and RAP Assessment documentation (as noted by location and date on the RAP Summary form), is there a requirement to write a RAP Summary note?

A: No. It is not necessary to summarize all information related to the RAP in one location. Documentation of the RAP findings and decision-making process may appear anywhere in the resident's record. It can be written in flowsheets, progress notes, in the care plan, in a RAP summary narrative, or on a RAP questionnaire, etc. However, the requirement is that you document information from the resident's assessment and staff's decision making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired care giver for this resident, will I be able to find and understand the assessment and decision making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note. No matter where the information is recorded, use the "Location and Date of RAP Assessment Documentation" column on the RAP Summary form to note where the RAP review and decision-making documentation can be found in the resident's record, and the date of the information. Also indicate in the column "Care Plan Decision" if the triggered problem is addressed in the care plan. Refer to the User's Manual, pages 4-10 through 4-18 for information concerning decision-making and documentation of the RAP findings, examples of assessment documentation using the RAP guidelines as a framework, and a Q & A section on frequently asked questions concerning RAP documentation.

169: In the example in the User's Manual on page 4-32, the Visual Function RAP is not checked as triggered, but in the example on page 4-27, D1 = 1. Should the Visual Function RAP have been checked in this example?

A: Yes. The Visual Function RAP triggered in this example, and should have been checked on the example RAP Summary form on page 4-32.

170: Why is the Visual Function RAP not triggered when D1 = 4? (Reference the User's Manual, page C-18).

A: Potential for visual improvement is not indicated if D1 = 4.

171: Please further explain the difference between ADL Rehabilitation triggers A and B.

A: Refer to the ADL RAP information in the User's Manual, beginning on page C-22. "The two MDS trigger

categories (A and B) suggest the types of residents for whom special care interventions may be most important. Such residents may have either the need and potential to improve (Rehabilitation) or the need for services to prevent decline (Maintenance)". If a resident triggers the ADL RAP, they will trigger ADL category A, B or both, as determined by the responses to MDS items linked with each category.

If category A is triggered, a rehabilitation/restorative plan of care is suggested. If category B is triggered, a plan of care designed to maintain function/avoid complications is suggested.

For residents who trigger both ADL categories A and B, category B takes precedence in the RAP review. A resident whose MDS indicates B4 = 3 (No ability to make decisions) is not a rehabilitation candidate, but rather an individual whose care plan would be designed to maintain function.

172: Is the ADL Supplement required when completing the ADL RAP?

A: The ADL supplement was designed to be a worksheet that may be of benefit to facility staff, but it is not required. The ADL Supplement was designed to help care planners to focus on ADL areas that might be improved, and may be particularly useful where rehabilitation goals are envisioned. Part 1 of the Supplement also helps to identify risk factors. Refer to the User's Manual, page C-25.

173: Regarding the Urinary Incontinence and Indwelling Catheter RAP (see the User's Manual page C-31) under "Abnormal Lab Values", are the examples of "tests that should have been done within the last 60 days" requirements or guidelines?

A: Use the test results if the tests were done within 60 days. Tests older than 60 days have no utility. The lab tests mentioned in the RAP may be appropriate to include in evaluating causal factors associated with incontinence. They are guidelines and should only be ordered if appropriate based on the specific resident's condition. This is determined based on the clinical judgment of the physician/health care provider responsible for ordering the laboratory tests.

174: What is the clinical/social rationale for item F1d, "Establishes own goals", to trigger the Psychosocial Well-Being RAP?

A: F1d identifies an area of strength for the resident, which may have implications for planning care to maximize resident functioning and quality of life.

175: The Behavioral Symptoms RAP trigger "Resists Care", (E4eA) is noted in the User's Manual, but does not appear in the SOM Transmittal #272. Which is correct?

A: The User's Manual is correct. See page C-43, which indicates "Resists Care, E4eA = 1,2,3" triggers the Behavioral Symptoms RAP. This was inadvertently omitted from page R-118 of the State Operation Manual (SOM), Transmittal No. 272. Change pages will be issued in a future SOM and also published on HCFA's World Wide Web site for Version 2.0.

176: Why does the combination of items N1a and N2 trigger the Activities RAP?

A: This combination of MDS responses has predictive value suggestive of possible overstimulation in

activities. Further assessment is therefore warranted. For example, the resident may be so involved in activities that he becomes too tired to eat. On the other hand, a high degree of involvement in activities may be used in a therapeutic manner by a resident who is depressed.

177: Regarding item N1, (see the User's Manual, page C-50), why is the Activities RAP triggered if just N1a, "morning" is checked?

A: Note that N1a alone does not trigger the RAP; rather, it must be present in combination with N2 = 0. Analysis of MDS data sets demonstrated that the "Morning", item N1a, was highly predictive (i.e., that this item was able to identify a high percentage of residents warranting additional assessment and care planning in this area). Triggers in Version 2.0 were studied to determine which triggers contributed most significantly to the identification of problems warranting care plans. Trigger items with low predictive validity were eliminated.

178: Please clarify the differences between Activities RAP triggers A and B, and how evaluation of the care plans would differ.

A: The Activities RAP triggers A and B point to very different treatment strategies. Trigger A identifies the need to evaluate expanded care/activity involvement when current involvement levels are low or new activity options are desired by the resident. Trigger B identifies the need to evaluate how to manage, and possibly reduce, activity patterns when involvement in activities is high and consistent throughout all waking hours of the day.

179: In Section O, Medications: Antidepressant (04b) and antianxiety (04c) medications both trigger the Falls RAP, but antipsychotic (04a) medication does not. However, when reviewing the Falls RAP, under the external risk factors, anti-psychotics are included. Should anti-psychotic medication trigger the Falls RAP?

A: Antipsychotic medications were not included in the Falls RAP for Version 2.0 because there is no predictive power gained by adding this group of medications.

180: Why does the Dental Care RAP trigger for residents who are edentulous and do not have or use dentures, and who receive daily mouth care?

A: For the Dental Care RAP, a follow-up review is required when one or more of the six conditions or oral hygiene problems are present. It is not self-evident that this three-item combination would not be appropriate for follow-up. For example, has there been a review for why dentures are not used? As noted in the User's Manual on page C-73, does the resident have the cognitive ability and motivation to wear dentures?

181: Are the Briggs modules by themselves sufficient evidence that the RAP protocols were used?

A: No. Briggs checklists may be used, but simply checking the boxes on the forms does not provide adequate, descriptive documentation regarding the resident's status as is required by the SOM transmittal #272. Analytic documentation should include risk/contributing factors, symptomatology, work-up and treatment, discussion of medication (if pertinent), and any resident/family involvement in the decision-making process. This may be written directly on the Briggs form if desired by the facility. See

examples of RAP documentation in Chapter 4 of the User's Manual.

Policy Issues

- Questions Regarding Significant Change, Significant Correction of Prior Assessment, Signature and Dating, Admissions of Less than 14 Days and Other Policy Issues

Significant Change

182: Is it necessary to complete a new RAI (MDS and RAPs) if the resident develops only one problem listed under the definition of significant change?

A: Generally no, as the guidelines for significant change included in the User's Manual on page 2-9 and 2-10 indicate, a significant change reassessment is appropriate if there are either two or more areas of decline or two or more areas of improvement. If there is only one change, however, staff may still decide that the resident would benefit from a comprehensive reassessment.

183: Please address the following situation regarding significant change:

A resident who has a 5% weight loss in 30 days and is not on a weight change plan begins to regain weight during the 14 day assessment period. Do we need to continue with the significant change, especially if the care plan already includes the problem, potential for weight loss?

A: First, a 5% weight loss in 30 days does not generally require a significant change reassessment in unless it is accompanied by a second area of decline from the list on page 2-9 of the User's Manual. Second, as the resident has started to regain the weight (and assuming the appropriate care plan interventions are in place), it is probably sufficient to continue to monitor the resident's nutritional status and weight gain, but delay conducting the comprehensive RAI reassessment unless it appears that the resident would benefit from an immediate reassessment and holistic revision of the care plan. Note that this answer assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss". This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring. However, each resident situation is unique and the interdisciplinary treatment team must make the decision as to whether the resident will benefit from an RAI. Refer to the User's Manual, page 2-8.

184: Can the Assessment Reference Date (item A3a) be the date the resident was admitted to the facility?

A: Yes. The date at A3a can be any date from admission until the 14th day following admission. When the admission date is used as the Assessment Reference Date, the assessment is based on information from an observation period that precedes the resident's stay (e.g., hospital records). Refer to the User's Manual, page 3-29.

185: Is it a requirement to complete a Significant Change Assessment if, as a result of a hip fracture, the only change is in the ADL areas?

A: No, if the only change is in the area of ADLs. However, other changes (such as the resident receiving

more support, incontinence or depression) often accompany a hip fracture. Given that the hip fracture often has a major effect on the resident and impacts on more than one area of the resident's health status, a significant change reassessment is often warranted. Refer to the User's Manual, pages 2-8 through 2-12 for guidelines concerning Significant Change.

186: Do staff have 14 days to decide if changes in the resident's status constitute a Significant Change? Once it is decided that a Significant Change occurred, do staff have 14 days to complete the Significant Change Assessment?

A: A Significant Change Assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the individual, but in no case later than 14 days after the determination was made that the Significant Change occurred. Refer to pages 2-8 through 2-12 of the User's Manual for guidelines concerning Significant Change.

187: Some providers are interpreting that Significant Change Assessments require two or more areas (as listed in the User's Manual) of decline before a new full assessment is to be done. For example, this interpretation would mean that a resident would require both a significant weight change and development of a pressure ulcer before a new assessment is required. The State Agency interpretation is that any change that impacts two or more areas of a resident's health status would trigger a new MDS. A pressure sore, for example, impacts multiple areas of health status: skin condition, nutrition/hydration, special treatments, more aggressive nursing care, mobility, psychosocial well being, etc. Which interpretation is correct?

A: The provider's interpretation is correct. A Significant Change assessment is appropriate if there is a consistent pattern of changes in two or more areas of decline or two or more areas of improvement from the MDS item categories listed on pages 2-9 and 2-10 of the User's Manual. These categories were identified by an empirical analysis of MDS data sets. A "Significant change" is defined as a major change in the resident's status that:

1. Is not self-limiting

2. Impacts on more than one area of the resident's health status; and

3. Requires interdisciplinary review or revision of the care plan.

Please note per the User's Manual that the lists of MDS item categories for Significant Change Assessment are not exhaustive. In fact, there may be other areas of decline or improvement that have such a profound impact on the resident and his or her needs for care that they would also appear to warrant a comprehensive reassessment.

188: If a resident develops a Stage II Pressure Ulcer and it heals in 10 days, is this a significant change?

A: Generally no. The facility will need to note the resident's condition in the clinical record and implement necessary clinical interventions. However, if the change in the resident is self-limiting and improves within two weeks, a significant change RAI would not be necessary. In this case, care plan changes such as

interventions to prevent the recurrence of a pressure ulcer would probably be appropriate. Review the conditions of significant change on pages 2-8 through 2-12 of the User's Manual.

189: Does an unplanned weight loss of 5% in 30 days trigger a Significant Change Assessment, if that is the only change?

A: Generally no, although it would be expected that the facility would note the resident's condition in the clinical record and implement necessary clinical interventions. In this case, a discreet assessment in the area of nutritional status may provide evidence of the extent of the problem, as well as information on which to base appropriate changes in the resident's care plan that will result in weight gain. However, if the problem persists or worsens, a comprehensive RAI reassessment may be clinically indicated. Review the criteria for significant change on pages 2-8 through 2-12 of the User's Manual.

190: If a resident has one area of decline and one area of improvement, do you need to complete a Significant Change Assessment?

A: No, a Significant Change Assessment is appropriate if there is a consistent pattern of changes in two or more areas of decline or two or more areas of improvement.

191: Is a Significant Change Assessment required when the only change in status is a weight loss of more than 10%? And in 3 months, at the time of the next scheduled assessment, if the resident did not re-gain or still has the 10% weight loss, is a second Significant Change Assessment required?

A: The answer is "No" for both questions, although the facility would be expected to assess and care plan for the weight loss, if it was not planned. If the weight loss continued on the subsequent assessment, it would probably be appropriate for the facility to indicate why the desired change had not occurred and to modify the existing care plan. For detailed information concerning guidelines for Significant Change, refer to the User's Manual, pages 2-8 through 2-12.

192: Are Quarterly assessments required when someone has had a Significant Change within the quarter?

A: In most States, a Significant Change in Status Assessment re-starts the assessment calendar for the individual resident. The next assessment due, (provided there has not been another Significant Change) is a Quarterly assessment conducted within 3 months of the Significant Change. Refer to the User's Manual, page 3-11, paragraph 5. If a Significant Change in Status is identified in the process of completing a Quarterly Assessment, code the assessment "3", Significant Change in Status, and complete a full assessment. Do not code this as a Quarterly review.

Please check with your State if you are unsure. For payment system purposes, in some States, a Significant Change assessment does not re-start the assessment calendar, or change the date the next Quarterly Assessment would be due.

Significant Correction of Prior Assessment

193: How is it handled when an MDS has been scored by two different staff members from one

assessment to the next, and due to a variance in interpreting how to score the assessment, it looks like a Significant Change has occurred, when it has not.

A: Complete a Significant Correction of Prior Assessment, (A8a=4). Reassess the resident by completing a new MDS and RAP Summary form, and revise the care plan if appropriate. Adherence to item definitions and instructions, as well as the requirements for completion of the assessment (e.g., interview direct care staff across all 3 shifts), should result in high rates of inter-rater reliability for MDS items. Variance in staff scoring the same resident may indicate a need for staff education on how to complete the MDS. Refer to the User's Manual, page 3-11.

194: If you find the last full assessment was wrong during the quarterly review, do you code quarterly review or significant change?

A: Code Section AA8 "S" for quarterly review on the Basic Assessment Tracking form which is completed along with the Quarterly Review assessment. However, if the quarterly review is not yet complete and staff decide to conduct a full reassessment, the quarterly review need not be completed. If inaccuracies are identified in the last full assessment, determine if those inaccuracies are such that a comprehensive reassessment is appropriate. Refer to the User's Manual, pages 2-26 and 2-27 for guidelines concerning when a Significant Correction Assessment is appropriate. If facility staff determine that a reassessment is necessary, initiate a full assessment and code the full assessment form Section A, item 8 (Reasons for Assessment) as a "4", significant correction of prior full assessment. This signifies that the resident's status is significantly different from the previous assessment as opposed to the resident having experienced a significant change in status. This process will identify your initiation of the required quarterly review assessment and your identification of significant inaccuracies requiring a reassessment.

195: Can a Significant Correction of Prior Assessment be performed on a Quarterly review, or only on a Full Assessment?

A: A Significant Correction of Prior Assessment may be necessary for a Quarterly Review assessment and a new Reason for Assessment (record type) has been created to allow for this. In the near future, HCFA will publish a revised MDS form and record specifications as well as information regarding the anticipated effective date. It will be available to software vendors on HCFA's World Wide Web site. On the revised form, Items AA8a4 and A8a4 will be relabeled "Significant correction of prior full assessment," and new Items, AA8a10 and A8a10 will be added, and labeled "Significant correction of prior Quarterly assessment." Change pages to the SOM will also be published. The change will not be formally required until the SOM is re-written.

Signature and Dating

196: Is it a requirement that the data entry person sign the MDS?

A: A specific MDS package may identify the MDS data entry person, but there is no HCFA requirement to do so. The MDS data record submitted to the State does not include such information.

197: May the facility staff use a signature stamp on the forms?

A: The use of signature stamps is allowed. The State Operation Manual Transmittal No. 274, survey protocol, F386, has the following guidance to surveyors on this topic: "When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the rubber stamp and uses it. A list of computer codes and written signatures must be readily available and maintained under adequate supervision." The State and facility may have additional policies or regulations that apply.

198: A facility utilizes a signature sign-in form for conferences where care planning and MDS forms are completed. May this type of signature and date form replace the signature and date on the MDS 2.0 form?

A: The text of the regulation CFR 42 483.20(c)(1)(ii) states that "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment". Further, CFR 42 483.20(c)(2) states that "Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment."

For a facility to use a signature sign-in form, the facility would need to have a written policy that explains how the sign-in process and format are used. It would have to provide attestation by the registered nurse regarding the completion of the assessment, and for each individual, who must certify the accuracy of the portion of the assessment that they completed. The State may have additional regulations that apply.

199: Is it true that there can be no more than 7 days between the date at A3a and the date at R2?

A: No. Note that A3a and R2 are independent of each other. A3a can be as early as the day of admission (i.e., it sets the endpoint of a common period of observation). The period of observation may be over long before the "forms" are actually completed, which is signified by the date R2b.

200: Please clarify the dating conventions for the Assessment Reference Date (A3a), the MDS Assessment Completion Date (R2), and the dates on the RAP Summary form at VB2 and VB4.

A: The Assessment Reference Date (A3a), signifies the end of the observation period for all assessment items. For example, for an MDS item with a 7-day period of observation, assessment information is collected for 7 days prior to and ending at the date at A3a; for a 14 day assessment item, the observation period is the 14 days prior to and ending at the date at A3a. A3a is the common date for which all observation periods end.

The Assessment Reference Date can be no later than 14 days after admission. A3a and R2 are independent of each other. The period of time between A3a and R2 is the time during which staff actually complete the MDS form. This activity is completed by the date at R2, which can be no later than 14 days after admission. It is allowable under the statute for the Assessment Reference Date (A3a) to be the same as the MDS Assessment Completion Date (R2). It may be more practical, although it is not a federal requirement, to leave some time between the dates at A3a and R2.

It would not make sense for the dates at R2 to precede the date at A3a, as this would indicate that the MDS form was completed before the observation period has ended. In this case, the MDS form would have been

completed before all observations were to have been completed. Remember that the date at R2b is the date on which the RN Coordinator is certifying the MDS as being complete, which is a statutory responsibility. Signatures and dates at R2c-h indicate that other staff members have accurately completed particular sections of the MDS. It makes sense, therefore, that the date at R2b should be no earlier than the latest date at R2c-h. In any event, dates at R2b-h can be no later than 14 days after admission. RAP review must be complete no later than 14 days following admission. If the MDS is completed (dated at R2b) earlier than the 14th day after admission, staff still have until the 14th day to complete the RAP portion of the assessment.

The date at VB2 on the RAP Summary form indicates that the RN Coordinator is certifying that the RAP review is completed. The date at VB2 can be no later than the 14th day after admission. The date at VB2 signifies completion of the RAI and can be used to determine the due dates of subsequent assessments.

The date at VB4 is the date that the care planning information required in column (b) of the RAP Summary form is completed. This column provides information on final care planning decisions for all RAP clinical conditions and may be completed by any professional staff member (i.e., it does not need to be completed by the RN Coordinator). It is completed after the interdisciplinary team has met and developed or revised the resident's care plan, incorporating the findings from that particular assessment. The date at VB4 can be no later than 7 days after the date at VB2, as the care plan must be completed within 7 days of RAI (MDS and RAPs) completion per Federal regulation. Refer to the User's Manual, pages 2-17 & 18, 2-28 & 29, and 3-29.

201: Is 12:00 midnight, at the end of the Assessment Reference Date (the date at A3), the last of the observation period? Or is 12:00 midnight, at the beginning of the Assessment Reference Date, the last of the observation period?

A: Observe across all three shifts, (24 hours per day) for the full observation period, (i.e.,: 7 days, 14 days, etc... as determined by the observation time periods noted at the MDS item). Allow for the full observation period to be sure to capture any events occurring in the appropriate time frame. HCFA has no requirement that the observation "clock" start or end at midnight.

202: Is it necessary to have the dietitian sign the MDS if they did not complete any portion?

A: No. The reference for this response is page 2-17 of the User's Manual, under "Certifying Accuracy and Completeness". Each individual team member who completes a portion of the assessment must sign and certify its accuracy. Team members should not sign the MDS if they did not complete any portion.

203: When the RN Coordinator completes sections of the MDS, does the Coordinator need to indicate those sections and sign under "other signatures" in Section R, or can it be assumed that the RN Coordinator who signs at R2a and dates R2b is the person who completed any sections not signed for by anyone else?

A: It is assumed that the RN Coordinator completed any portions of the MDS that have not been designated by other staff. The RN Coordinator must sign at ADa and R2. The RN Coordinator signs at ADa when the Face Sheet portion is complete, and signs at R2a to certify that the MDS is complete. Refer to the User's Manual, page 3-167. Federal regulations at 42 CFR 483.20 (c)(1) and (2) require each individual who completes a portion of the assessment to sign and certify its accuracy. If the RN Coordinator also completed sections of the MDS, signature at R2a is sufficient. If the RN completing the MDS sections is not the

Coordinator, that RN signs under R2c-h, and the Coordinator signs at R2a.

204: Please confirm that the day of admission counts as day 0, not as day 1. There are conflicting examples in the User's Manual.

A: The day of admission is counted as day 0 under Federal policy. The example shown on page 2-6 is clear and consistent with Federal interpretation of the OBRA '87 requirement. The example on page 3-30 is incorrect. In this example, day 7 following an admission on 8/20/94 would be 8/27/94, and day 14 would be 9/3/94.

Counting the day of admission as day 0 allows the maximum flexibility in terms of time to complete the RAI. For case-mix/reimbursement purposes, however, some States require that the day of admission be counted as day 1.

Admissions of less than 14 Days

205: If a resident enters the facility and does not stay at least 7 days, is it necessary to begin an MDS?

A: No. The MDS/RAI does not need to be completed, either in part or in entirety, unless the resident has been in the facility 14 days or longer. Refer to the User's Manual, page 2-4.

206: If an individual is hospitalized for several days during the initial 14 days of the NF stay, is the MDS still due on day 14, or when would it be due? For example, if the resident is hospitalized day 2 thru day 12, and returns on day 13.

A: The facility would have 14 days after "readmission" to the facility to complete the RAI. Refer to the User's Manual, page 2-7.

207: What subset of information must be completed on short-term respite admissions, when a resident expires or is discharged prior to day 14?

A: Currently, there is no required subset of information. Once HCFA's automation requirements are effective, facilities will be required to complete the Discharge Tracking form. See page 3-2 of the User's Manual.

208: Must an MDS be completed for a respite stay of less than 14 days?

A: No. Keep in mind, however, that there should be a process in place to identify the resident's needs and to initiate a plan of care to meet those needs upon or shortly after admission. Refer to the User's Manual, page 2-6.

209: If a resident is discharged on the 14th day, would the facility still be required to complete the entire MDS?

A: No. Refer to the User's Manual, page 2-6. Keep in mind, however, that evidence of assessment and care planning to meet the resident's needs should be in place, and have been initiated on or shortly after

admission. Once computerization requirements are effective, facilities will be required to complete a discharge tracking form for all residents admitted to the facility regardless of length of stay.

Other Policy Issues

210: What is the date of HCFA's final version of the MDS 2.0?

A: The current version is dated 10/18/94N. However, HCFA has a commitment to continue to refine the instrument to reflect state-of-the-art practice standards and assessment methodologies, and accommodate the changing needs of the nursing home population. In that regard, there will not be a "final" version. The transitional MDS that contains minor changes as noted in this document (and on the World Wide Web site) will be dated 10/18/94H. Information regarding the anticipated effective date of 10/18/94H is pending.

211: Is there a requirement to have additional assessments in place that substantiate information documented on the MDS?

A: No. From a Federal perspective, the MDS is considered a primary source document, as it is part of the clinical record. However, some States require documentation that validates MDS coding as the MDS is used to derive payment. A different but related question is whether the MDS and RAPs alone provide a comprehensive assessment as is required by Federal regulations. Neither the MDS or RAPs covers every conceivable area that may be pertinent to a resident's needs and care. Such areas must nevertheless be addressed in the resident's clinical record and on the care plan. There is not a Federal requirement specifying the format of such documentation, only that it be a part of the resident's clinical record. Such information can be maintained, for example, in progress notes, or on flow sheets. Documentation systems and the order and format of information in the clinical record is generally a matter of facility policy. Refer to the User's Manual Section 4.9, pages 4-18 through 4-23.

212: Is it necessary to reassess on an annual basis the need for a feeding tube for patients who require this intervention? Also, would a goal for a tube fed resident be to eventually have them back on a solid diet?

A: The answer to both questions is yes. If the Feeding Tube RAP is triggered, reassessment is required at least yearly (i.e., with each annual assessment) and perhaps more frequently, if clinically warranted. Refer to the RAP, beginning on page C-62 of the User's Manual and note that restoration to normal feeding should remain the goal throughout the treatment program. Comprehensive reassessment and evaluation allows the interdisciplinary treatment team to determine if this is an achievable goal. For some residents, this may not be realistic. For others, it might be a suitable long-term goal, where an intermittent short term goal, (i.e., to tolerate thickened fluids p.o.) might be more appropriate. Note the guidance provided on page 4-16 of the User's Manual (regarding the extent of reassessment and documentation required for subsequent reassessments after a comprehensive evaluation (i.e., for a neurological swallowing deficit) has been conducted.

213: Is there a requirement to document on the resident's plan of care the number of bed days used?

A: No. There is not a Federal requirement that bed days be documented on the plan of care. Check with your State regarding whether there is an existing State code, rule or regulation.

214: When does the 15 month requirement for MDS 2.0 record keeping start? Do we have to keep 15 month's worth of records on computer files?

A: Per the State Operations Manual (SOM) Transmittal #272, with the implementation of Version 2.0, facilities are required to have 15 months of assessment data in the resident's active clinical record. This includes all MDS forms, RAP Summary forms and Quarterly Assessment forms as required during the previous 15 month period. For the 15 months immediately following MDS 2.0 implementation, facilities will have a combination of MDS 2.0 and MDS version 1 information in the active records. Refer to the User's Manual, page 2-18. Note that this time period was decreased from the 24-month period required by SOM Transmittal #241.

RAI information completed 15 months ago or longer may be thinned from the active record and stored in the medical records department, provided the information is easily retrievable if requested by clinical staff or State Agency surveyors. The exception is that Face Sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged. If the resident returns to the facility following a discharge (i.e., a situation in which the record has been closed), the facility should copy the original and place it in the resident's new record. The above also applies to facilities that maintain an electronic clinical record, except that a hard copy of the RAI need not be maintained if the entire clinical record is stored electronically, and the additional conditions on page 2-19 of the User's Manual are met.

215: Is it required that staff members write on the Interdisciplinary Care Plan when goals are met and approaches are changed, if the changes are already documented in progress notes?

A: Yes, the care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool. Review 42 CFR 483.20 (d), Comprehensive Care Plans. There is a Federal requirement that the comprehensive care plan include measurable objectives and time frames, and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care. Refer to the RAI User's Manual, pages 2-27 through 29 regarding the linkage of MDS and RAPs to the formulation of the care plan, and refer to the SOM Transmittal # 274, (F Tag 279), "The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care".

216: How long do facilities have to update all residents to the MDS 2.0 after the January 1, 1996 implementation date? Will the 2.0 assessment be phased in according to the resident's annual assessment schedule?

A: As of the State's implementation date, the next MDS due for each resident, regardless of reason for assessment, (and whether it is a Quarterly or Full assessment), is done using the appropriate MDS 2.0 form. In this manner, all residents in the facility will have a Quarterly or Full assessment using Version 2.0 within 3 months of the implementation date. All subsequent assessments are also done using the MDS 2.0 form. For Quarterly Assessments, be sure to use the Quarterly Assessment form specified by your State. State RAIs may also include Sections S, T and U. Note: Not all States implemented Version 2.0 as of January 1, 1996. If you have questions, check with your State.

217: Is it okay for a resident or family member to complete sections of the MDS?

A: No. Refer to the User's Manual, page 2-16. Facility staff are required to include the resident and family in the assessment and care planning process, but this means that they are key sources of information for assessment data, not that the resident or family should be involved in completing the "forms" themselves. It is the facility's responsibility to complete the assessment and ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. A facility may assign responsibility for completing the RAI to a number of qualified staff members who are generally licensed professionals. The MDS was developed to be completed by professional staff members. It was not designed for self-reporting of information.

218: While the User's Manual states that it is not "required to assess a resident if he/she is readmitted" (page 2-12), can the facility elect to complete a full comprehensive RAI on any readmission, even if it is after a temporary absence?

A: Certainly, and many facilities have adopted such policy. However, it is not a Federal requirement.

219. After receiving approval from HCFA for the MDS instrument or alternate instrument specified by the State, some States are making further additions or changes to the instrument. Please advise.

A: HCFA is aware of this situation and is in the process of following up with individual States. Per the SOM Transmittal #272, all States are required to notify HCFA of their intent to adopt HCFA's RAI or request approval of an alternate instrument. States are then required to implement the instrument that HCFA has approved for use by all long term care facilities within the State. States may not subsequently change the State RAI unless approval has been granted in writing by HCFA.

Questions on MDS Quarterly

220: Regarding item A4a of the Quarterly and Annual Assessment, if the resident has not been hospitalized, is the item left blank?

A: Yes. For both the Full and Quarterly Assessments, if the resident has not been hospitalized in the past 90 days, leave this item blank. The User's Manual reference for this question is on page 3-31.

221: On the Quarterly Assessment, how do you set the date at item A3?

A: The date is set by the RN Coordinator in the same way as for the admission and annual assessments. This Assessment Reference Date is the last day of resident observation for the current quarterly assessment. This date sets the designated endpoint of the observation period, and all MDS items refer back in time from this point. Refer to the User's Manual, page 3-29. There is not a specific requirement for the date at A3 for a Quarterly Assessment. Data specifications on timing edits are based on the date at R2b.

A Quarterly Assessment must be completed in each 3 month period, in-between Full Assessments (i.e., annual or significant change). Refer to User's Manual, page 2-13.

222: For a resident whose annual review comes due in the middle of 1996, which Quarterly

Assessment form is to be used?

A: Regardless of whether the last full assessment was completed using version 2.0, use the Quarterly Assessment Form for Version 2.0 for all quarterly reviews completed after the State's version 2.0 implementation date. For most States, this was January 1, 1996. Check with your State to find out whether the standard or the expanded Quarterly Assessment form was specified for use by the facilities in the State.

223: On page B-14, Section I1., Diseases: z., quadriplegia is out of order on the RUG III Quarterly Assessment Form. In Section I3b, the decimal point is missing on the ICD-9 code.

A: These items are noted and changes will be released on the World Wide Web site soon. A copy of the transitional MDS form is included with this document.

224: When completing a Quarterly Assessment, what are the requirements regarding holding a care conference?

A: The Quarterly MDS offers an opportunity to review the resident's status and progress but there are no Federal requirements that mandate the interdisciplinary team have a face-to-face meeting for this purpose. The facility determines how to approach updating the care plan, as indicated, based on the current assessment. Refer to the User's Manual, page 2-13 for the intent of the statement "based on the Quarterly Assessment, the resident's care plan is revised if necessary".

225: Is RAP Summary documentation required for Quarterly Assessments?

A: RAP review is only required for full assessments. Refer to the User's Manual, pages 4-16 through 4-18, for guidelines concerning RAP documentation. Certain vendor's MDS forms label trigger items on the form. For a Quarterly Assessment, this should not be construed as a requirement to complete RAPs.

226: In completing a Quarterly Assessment, is it required to complete a "full, comprehensive assessment", including RAPs and triggers, or just the subset of MDS items on the Quarterly assessment?

A: Though the Quarterly assessment requirement varies from State to State, HCFA has specified a subset of key MDS items that make up the Quarterly Review under Federal requirements. The Quarterly Review is used to track the resident's status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in the resident's status.

Each State's RAI includes HCFA's Quarterly Review items at a minimum. However, States may add items from the core MDS, their Section S, or Sections T or U. They may even require the "MDS" portion of their RAI (i.e., everything except the RAPs) be completed each quarter. One popular alternative, particularly for States that are using the MDS to support payment systems, is HCFA's optional RUG III Quarterly Review form, found on pages B-13 through B-15 of the User's Manual. If you are unsure, check with your State RAI Coordinator (listed in Appendix A of the User's Manual) to determine what is required in your State.

227: Does a request need to be made to HCFA to use the optional 3 page Quarterly?

A: Yes. The State determines the need to add items to the MDS or Quarterly Review form and requests approval from HCFA to specify an alternate instrument for use by all facilities in the State.

228: If the State specifies the standard Quarterly instrument, can a facility opt to use the expanded (RUG III) version? (Note: the SOM refers to the standard quarterly and calls for using all and only that information).

A: A facility is required to use whatever Quarterly Review instrument has been specified by their State. However, facilities have the prerogative of adding items to the core MDS or Quarterly Review, provided that they are capable of separating this information and reproducing the State-specified RAI. Contact your State's RAI Coordinator (listed in Appendix A of the User's Manual) if you have questions.

Questions on MDS Automation

229: Are facilities required to complete the Basic Assessment Tracking Form prior to implementation of the Data Automation Requirement?

A: Yes, a copy of the Basic Assessment Tracking form must accompany each Full or Quarterly Assessment that is completed. Refer to page 3-1 of the User's Manual.

230: Section AA, item 8 on the Basic Assessment Tracking form, Section A, item 8 on the Full assessment, and Section AA, item 8 on the Reentry Tracking form all refer to the same 2 digit field on HCFA's MDS 2.0 record layout/data dictionary. Also, the record specifications indicate all assessment items except those on the Reentry Tracking form [Section AA, items 1-9 and Section A, items 4a, 4b (this is not on the full form), and 6] are blank on record type R (Reentry).

Since all Reason for Assessment references apply to the same 2 digit field, it is impossible to enter both an "09" and an "03" as the reason for assessment in the transmission record. Also, the processing of record type R's will only look to the limited number of responses contained on the Reentry Tracking form.

A: Once a resident is "discharged" from the system (i.e., a Discharge Tracking form is completed, signified by use of "06", "07", or "08" as the reason for the assessment), a Reentry Tracking form must be completed on the resident's "reentry" to the facility. If a significant change in status has occurred, the facility then must complete a comprehensive assessment (i.e., the MDS and RAPs). In this case "03" is entered as the Reason for the Assessment. Each "assessment" process requires a separate "transaction", which is indicated by the corresponding record type code.

231: Do facilities entering MDS data into a computer have 7 days from MDS completion (date at R2b) to make changes/corrections as are necessary to pass the edit process?

A: It's more advantageous for facilities to use 7 days from the date at VB2. Technically, the correct date to use to calculate when the electronic record must be locked is VB2. See the User's Manual pages 2-25 and 2-26.

232: Would the date at R2b plus 7 days be the most logical date to trigger an automatic lock? Would

this also apply to Quarterly MDS's?

A: The date to trigger an automatic lock is seven days after VB2 for all full assessments (i.e., those for which RAPs are required). Use R2b to calculate the automatic lock date for all Quarterly assessments.

233: Regarding Chapter 2-18, "Electronic vs: Clinical Record", does this pertain to "paperless" facilities? If a facility is not completely automated and doesn't have the entire clinical record stored in the computer, do they have to have a paper MDS? RAI? If the MDS alone is in the computer, is a hard copy required?

A: The answer to each of the questions is yes. Refer to the User's Manual, pages 2-18 and 2-19.

234: The RAI Manual indicates that a check mark must be used in certain fields. HCFA's Web site indicates that a capital X may be used in lieu of the check mark when processing the MDS in the computer. Is the capital X still an acceptable symbol for the check mark?

A: Yes.

235: When will all States be required to submit MDS data electronically? (When will HCFA's ADP requirement be in effect?)

A: HCFA anticipates the MDS automation requirements will become effective in mid 1997, after publication of final regulations related to the RAI.

< p align=justify>236: Will HCFA place vendors on mailing lists for immediate notification regarding RAI updates/information?

A: Due to the large number of software vendors and limited internal resources, HCFA is unable to maintain a mailing list or mail information directly to software vendors. To provide vendors with the most up-to-date information in a timely manner, HCFA established an MDS 2.0 World Wide Web site at the University of Wisconsin. The Web address is:
http://linear.chsra.wisc.edu/mds_info.htm

Or, alternatively you can jump to the CHSRA home page and follow the prompts to the MDS information pages. The CHSRA home page address is:

http://www.chsra.wisc.edu

The Internet e-mail account for technical questions is:
mds_info@chsra.wisc.edu

237: Is the CFR information available on-line for outside queries?

A: The Code of Federal Regulations is available on CD ROM.

238: Is there an acuity tool available that matches the MDS 2.0?

A: A case-mix classification system, RUGs III, is available and is being used by many States to support Medicaid payment systems. It is also being evaluated for potential use as a prospective payment system for Medicare. It is available on HCFA's World Wide Web site.

239: Nurses are using MDS data to do Quality Assurance Studies. They put data into the computer on a weekly basis, without locking it in. Can they do this?

A: Provided it doesn't interfere with State and Federal requirements pertaining to MDS implementation and electronic submission. Not all vendors provide this capability. Refer to HCFA's policy on Expectations for Facility Automation.

240: Will HCFA be recommending software that meets HCFA specifications?

A: HCFA's policy on Expectations for Facility Automation addresses what function MDS software programs will have to perform. However, HCFA cannot recommend specific software products or give guidance to the industry on whether specific products meet the HCFA specifications.

241: What is the requirement for the arrangement of the MDS when printed from a computer?

A: Basically, it should be formatted like the HCFA MDS. Refer to the SOM Transmittal #272, 4145.5, Variations in Formatting the State-Specified RAI. "States are encouraged to permit some flexibility in form design (for example: print type, color, shading, or integrated triggers) or through use of a computer-generated printout of the RAI. HCFA's approval is not required for you to permit such formatting variations. However, you must assure that any RAI form or printout in the resident's record accurately and completely represents your RAI as approved by HCFA, in accordance with 42 CFR 483.20 (b). That is, it includes all and only the items on your instrument with the exact wording and in the same sequence". If a manually completed MDS form is not placed in the clinical record for a resident, then a computer printout of the MDS must either be produced and placed in the clinical record or must be produced on demand (i.e., of a staff member or State Agency surveyor). This printout must be a replica of the paper MDS form, with all items in similar positions and on the same pages as the paper form.

242: If the MDS is computerized, will the new Quarterly Assessment information update the old MDS, so that when the new MDS is run, it will automatically be updated?

A: Each individual record must be "locked" per HCFA's policy on Expectations for Facility Automation. Locked records cannot automatically be copied to form the basis for subsequent assessments without the assessor verifying that each individual item response is accurate for the new assessment record.

243: For MDS data entered into a computer real-time by the assessor, is there a requirement for an additional item-by-item entry into the computer to confirm the accuracy of each response?

A: When completed real-time, the Assessor is responsible for reviewing each item for each required assessment, discharge or reentry. How this is accomplished is a matter of facility policy. Physical confirmation is not required. Visual review is adequate.

Questions Regarding the RAI Process and Survey

244: Is it possible to be on a medication, e.g., a diuretic or pain medication, without a diagnosis?

A: A resident should not be on a drug without a valid reason, e.g., symptomatology that justifies the use of the drug. Refer to the CFR 483.25 (l) (1) regarding "Unnecessary Drugs - General". Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is defined as a drug used without adequate indications for its use. Guidance to Surveyors calls for surveyors to allow the facility the opportunity to provide a rationale for the use of the drug(s), and the facility may not justify the use of a drug solely on the basis of a doctor's order. F tag 329 includes the following note: "The unnecessary drug criterion of "adequate indications for use" does not simply mean that the physician's order must include a reason for using the drug (although such order writing is encouraged). It means that the resident lacks a valid clinical reason for use of the drug as evidenced by the survey team's evaluation of some, but not necessarily all, of the following: resident assessment, plan of care, reports of significant change, progress notes, laboratory reports, professional consults, drug orders, observation and interview of the resident, and other information.

245: A particular state agency is mandating that only narrative documentation can be used for RAP review documentation, and is giving deficiencies if any other format is used. Please comment.

A: The guidelines found in the SOM Transmittal #272 address the content, but not the format of RAP review documentation. Indeed, in Chapter 4 of the User's Manual, it is clear from both the text and documentation examples that facilities have a great deal of flexibility in how this documentation is done. Citing facilities for failing to use a narrative format cannot be supported under the Federal requirements. Rather, HCFA provides guidance on key documentation issues as outlined in SOM #272, and in the examples of appropriate documentation in Chapter 4 of the User's Manual. If it is not clear that a facility's documentation provides this information, surveyors should ask facility staff to provide such evidence.

246: Now that the enforcement regulation refers to each resident, if assessment or RAP documentation information is inadequate, is it appropriate to cite 272 even if there is only an occurrence for one individual?

A: It's difficult to provide precise guidance on what constitutes an inadequate assessment. Generally speaking, this decision should be based on whether the resident received appropriate care to meet his medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. As stated in the regulations at CFR 483.20, the comprehensive assessment provides the foundation for the development of a care plan that meets these needs. If the facility did not accurately identify and care plan for the resident's needs because of an inadequate assessment, this could be cited as a deficiency.

247: Regarding the balance test, item G3, sometimes residents are unwilling to participate, despite instruction and support. Will surveyors accept that the resident declined to participate? Should staff document extensively that the resident declined to participate?

A: In approaching a resident for a balance test, staff should provide privacy and an explanation. The resident may, of course, decline the test but the facility should attempt to determine why the resident is refusing. Since this would affect the MDS response, it seems worthy of a short notation which may be written directly on the MDS form. Surveyors will accept individual residents declining to participate, but will probably be suspicious if an untoward number of residents decline participation in this test.

248: Are Activity Department staff required to write monthly or quarterly progress notes?

A: There is a Federal requirement for progress notes, but there is not a Federal regulation regarding the frequency of progress notes for any discipline. Refer to CFR 483.75 (l) (1), Clinical Records, which requires the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are (i) complete, (ii) accurately documented, (iii) readily accessible, and (iv) systematically organized. See also F Tag 514. As a practical matter, progress notes should facilitate interdisciplinary team communication and coordination of care. Review your State codes, rules and regulations, professional practice standards and facility policy.

249: Regarding RAP documentation: How much documentation is enough? For example, if a resident is incontinent and most documentation is present, but there is no note re: family involvement in the care plan, should the survey team cite this?

A: Not necessarily. Refer to the examples of resident assessment documentation in the User's Manual on pages 4-11. The main issue is whether facility staff have documented key findings regarding the resident's status and associated implications for care. If the family is particularly involved in the resident's care or concerned about the incontinence problem, then it may be appropriate for some reference to the family appear in facility documentation. However, surveyors should not expect to see references to family involvement for each triggered RAP or care plan problem.